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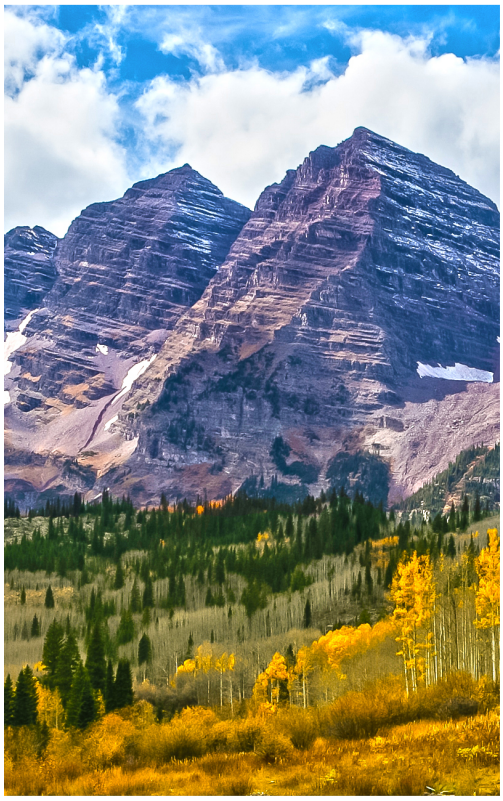
DEPARTMENT OF HUMAN SERVICES

ADULT PROTECTIVE SERVICES



MAY 2020

PERFORMANCE AUDIT

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DIANNE E. RAY, CPA
STATE AUDITOR

May 21, 2020

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Adult Protective Services Program at the Department of Human Services. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., which requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments for purposes of the SMART Government Act. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Human Services.

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REPORT HIGHLIGHTS

ADULT PROTECTIVE SERVICES

PERFORMANCE AUDIT, MAY 2020

DEPARTMENT OF HUMAN SERVICES

CONCERN—The Department of Human Services (Department) should improve its operations and oversight of the Adult Protective Services Program (Program), including processes related to Colorado Adult Protective Services system (CAPS) background checks for perpetrators who have been substantiated of mistreating at-risk adults; appeals for perpetrators; and county screening of reports of mistreatment and self-neglect, investigations, and guardianships of at-risk adults.

KEY FINDINGS

- CAPS checks do not report sufficient information on findings of mistreatment to employers to help them make fully informed employment decisions; reporting could be improved to better achieve statutory intent to protect at-risk adults.
- We identified policy areas that the General Assembly may want to consider that could help further protect at-risk adults, such as prohibiting employers from hiring certain perpetrators and requiring CAPS checks on existing employees.
- The process for perpetrators to appeal substantiated findings of mistreatment is not designed or operating as well as it could to protect at-risk adults. For 78 of the 80 appeals that the Department upheld in Fiscal Year 2019, its settlement agreements made the mistreatment findings unreportable in a CAPS check.
- Between July 2018 and December 2019, the Department did not resolve 205 of the 469 appeals filed (44 percent) within the 120 calendar days required in rule.
- In Fiscal Year 2019, counties incorrectly screened out 19 of 108 sampled reports of mistreatment and/or self-neglect of at-risk adults (18 percent) instead of investigating them.
- For 24 of the 103 sampled cases (23 percent) in Fiscal Year 2019, the county investigations, service coordination, and/or case documentation did not follow statute or rules. Problems included incomplete investigations and assessments of at-risk adults, inaccurate findings, and untimely case plans and visits with adults.
- For 14 of the 15 county guardianship cases sampled (93 percent), we could not determine whether the counties followed statute and rules when petitioning for guardianships of at-risk adults due to insufficient county documentation.

BACKGROUND

- Colorado's Adult Protective Services Program was established in 1983 to provide safety and protection for at-risk adults who are, or suspected to be, victims of mistreatment and/or self-neglect, and cannot address their circumstances without assistance. At-risk adults are aged 18 and over and are unable to perform or obtain services or lack sufficient understanding to make decisions for their health, safety, or welfare.
- County departments of human/social services receive and investigate reports of mistreatment and self-neglect of at-risk adults and provide them services. The Department oversees the counties' Program operations and administers CAPS checks and appeals.
- In Fiscal Year 2019, counties received 25,001 reports of mistreatment or self-neglect of at-risk adults, conducted 7,735 investigations, and substantiated 1,343 acts of mistreatment committed by perpetrators.

KEY RECOMMENDATIONS

- Improve the descriptive information reported to employers through CAPS checks.
- Instruct appeal reviewers on when to uphold county findings and pursue settlement agreements, document these decisions, and improve the timeliness of appeals decisions.
- Train counties on screening reports of mistreatment and/or self-neglect and conduct reviews of screened out reports.
- Improve county investigations with training and by addressing problems identified by the audit and Program reviews.
- Implement written guidance and training for documenting county guardianships.

The Department agreed with most of the audit recommendations.

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CHAPTER 1
OVERVIEW

Colorado's Adult Protective Services Program (Program) was established in 1983 to provide for the safety and protection of at-risk adults who are, or are suspected to be, victims of mistreatment and/or self-neglect, and are unable to address their circumstances without assistance. An at-risk adult is defined as a person aged 18 or older who is susceptible to mistreatment or self-neglect because they are unable to perform or obtain services necessary for their health, safety, or welfare; or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning their person or affairs [Section 26-3.1-101(1.5), C.R.S.].

MISTREATMENT is an act or omission that threatens the health, safety, or welfare of an at-risk adult, or that exposes them to a situation or condition that poses an imminent risk of bodily injury [Sections 26-3.1-101(7)(d) and (e), C.R.S.]. Statute defines the types of mistreatment against an at-risk adult as follows:

- **ABUSE** includes the nonaccidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, fractures, poisoning, subdural hematoma, swelling, or suffocation; confinement or restraint that is unreasonable under generally accepted caretaking standards; or subjection to criminal sexual conduct or contact per the Colorado Criminal Code, Title 18, C.R.S., [Section 26-3.1-101(1), C.R.S.].

- **CARETAKER NEGLECT** occurs when adequate food, clothing, shelter, psychological/physical/medical care, supervision, or other treatment necessary for the adult's health or safety is not secured or 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 the adult [Section 26-3.1-101(2.3), C.R.S.].

- **EXPLOITATION** is an act or omission committed by a person who uses deception, harassment, intimidation, or undue influence to deprive the adult of the use, benefit, or possession of anything of value; forces, compels, coerces, or entices the adult to perform services, or employs the services of a third party, for the profit or advantage of the person or another person to the detriment of the adult or against the adult's will; or misuses the adult's property in a manner that adversely affects their ability to receive care or benefits or to pay bills [Section 26-3.1-101(4), C.R.S.].

SELF-NEGLECT is an act or failure to act whereby an at-risk adult substantially endangers their own health, safety, welfare, or life by not seeking or obtaining services necessary to meet their essential human

needs. Choice of lifestyle cannot, by itself, be evidence of self-neglect, and refusal of treatment in accordance with a valid medical directive or palliative plan of care is not self-neglect [Section 26-3.1-101(10), C.R.S.]. There is no perpetrator involved in allegations of self-neglect.

In Colorado, the Program is administered by the State's 64 county departments of human/social services and overseen at the state level by the Department of Human Services (Department). Anyone can report suspected mistreatment or self-neglect of a potentially at-risk adult to a county by phone, email, fax, or in person. Statute urges people working in certain occupations to report to the county any suspected or known mistreatment or self-neglect of an adult who is believed to be at-risk [Section 26-3.1-102, C.R.S.]. These occupations include paid and unpaid health care workers, pharmacists, therapists, counselors, hospital and long-term care personnel that admit or care for patients, first responders, victim advocates, medical examiners, social workers, service providers for at-risk adults, school personnel, and clergy, among others who treat, serve, or counsel at-risk adults [Section 26-3.1-102, C.R.S.]. Statute requires these occupations to report suspected or known mistreatment of an at-risk adult to law enforcement agencies, which then must report the allegations to the county if the adult is 70 years or older or has an intellectual and developmental disability [Sections 18-6.5-102(2) and 108, C.R.S.].

PROGRAM RESPONSIBILITIES

Statute outlines the Program's responsibilities and functions, as follows:

RECEIVE AND SCREEN REPORTS OF MISTREATMENT AND SELF-NEGLECT [SECTIONS 26-3.1-102 AND 103, C.R.S.]. When a county receives a report, staff enter it into the Colorado Adult Protective Services system (CAPS), which is the Program's electronic report and case management system. Counties must also share all reports with local law enforcement, which determines whether to conduct a criminal investigation of the information in the report. The county reviews each report to determine whether it involves (1) an at-risk adult and (2) mistreatment and/or self-neglect. A report that meets both criteria is screened in and investigated,

while reports that do not meet both criteria are screened out and are not investigated. EXHIBIT 1.1 shows the number of reports of mistreatment and/or self-neglect that counties received in Fiscal Years 2017 through 2020, as of March 31, 2020.

EXHIBIT 1.1. ADULT PROTECTIVE SERVICES
REPORTS OF MISTREATMENT AND/OR SELF-NEGLECT
FISCAL YEARS 2017 THROUGH 2020, AS OF MARCH 31, 2020

REPORT TYPE	2017	2018	2019	2020
SCREENED OUT	12,955	14,982	17,266	13,388
SCREENED IN	7,374	7,601	7,735	5,582
Mistreatment	4,061	4,401	4,751	3,476
Self-Neglect	2,692	2,623	2,267	1,813
Mistreatment and Self-Neglect	621	577	717	293
TOTAL REPORTS	20,329	22,583	25,001	18,970

SOURCE: Office of the State Auditor analysis of data from the Colorado Adult Protective Services system (CAPS).

INVESTIGATE ALLEGATIONS [SECTION 26-3.1-103, C.R.S.]. The counties are to investigate reported allegations of mistreatment and/or self-neglect of adults who are known or suspected to be at-risk. Reports are screened out, and no further action is taken, if they do not involve a suspected at-risk adult or allegations of their mistreatment or self-neglect. Reports that are screened in are referred to as cases. If a county determines that an investigation is required, it is responsible for ensuring that an investigation is conducted and arranging for protective services. As part of investigations, county caseworkers interview the adult and any alleged perpetrator(s) in the case, as well as others with knowledge of the adult's circumstances such as caretakers and family members, and collect relevant evidence such as medical and financial records. The county makes a finding as to whether there is a preponderance of evidence showing that the alleged perpetrator committed mistreatment, and if so, the county substantiates the allegations [Section 30.520, 12 CCR 2518-1]. In this report, we refer to individuals substantiated of committing mistreatment as "perpetrators." Counties document their investigations and findings in CAPS [Section 30.260.A, 12 CCR 2518-1] and send letters to perpetrators to notify them of the findings. In Fiscal Year 2019, counties substantiated 1,343 acts of mistreatment against at-risk adults in Colorado.

Assess the adult for needed services [Section 26-3.1-103, C.R.S.]. For each case, the county must conduct an assessment to determine the adult's strengths and needs, and the services that he or she may need to reduce risk and improve health and safety [Section 30.530, 12 CCR 2518-1]. The assessment includes evaluating the adult in areas such as the adult's living environment, cognitive functioning, and ability to carry out daily living activities such as bathing, feeding, and managing medication and personal finances. Based on the assessment, the county develops a case plan for the adult that identifies the services needed.

Coordinate protective services [Sections 26-3.1-101(9), 103, and 104, C.R.S.]. Services are intended to prevent the mistreatment or self-neglect of an at-risk adult. Services, which are typically provided by third-party vendors, can be temporary or ongoing. Such services vary for each adult and can include providing protection from mistreatment; coordinating and monitoring medical care for physical and mental health needs; in-home care such as home health nursing assistance and cleaning; food assistance; help applying for public benefits; and referral to community service providers.

In line with the 1999 United States Supreme Court decision [*Olmstead v. L.C.*], statute specifies that adult protective services must constitute the least restrictive intervention, meaning that they must be delivered in the least restrictive environment available, for the shortest duration, and to the minimum extent necessary to remedy or prevent mistreatment or self-neglect [Sections 26-3.1-101(6) and 104(3), C.R.S.].

Petition for guardianship, when appropriate [Section 26-3.1-104(2), C.R.S.]. If the county finds that an at-risk adult has been mistreated or has been self-neglecting and appears to lack capacity to make decisions, statute states that counties are urged, if no other appropriate person is able or willing, to petition the court to become the adult's guardian or conservator. A guardian makes decisions regarding the adult's support, care, health, and welfare, as necessitated by the adult's limitations and as stated in a court order [Section 15-14-314, C.R.S]. Conservators are fiduciaries who manage the finances and assets of the adult [Section 15-14-418, C.R.S.]. Thirty counties held a

total of 479 temporary or permanent guardianships of at-risk adults in Fiscal Year 2019.

MANAGE CAPS BACKGROUND CHECKS [SECTION 26-3.1-111, C.R.S.]. Effective January 2019, statute requires certain employers and contractors that have direct care staff who work with at-risk adults, including nursing homes and adult day programs, to contact the Department to request a CAPS check of a prospective direct care employee to determine if they have had substantiated findings of mistreatment. The purpose of CAPS checks is to minimize the potential for employment of persons with a history of mistreatment of at-risk adults in positions that would allow those persons unsupervised access to these adults. When an employer requests a CAPS check from the Department, they may receive information about substantiated findings including the type, severity, and date of the mistreatment that occurred, and the county where it occurred. In Calendar Year 2019, when the CAPS check process began, the Department conducted 109,066 CAPS checks for employers, which identified 169 potential employees or contractors who were perpetrators.

PROCESS APPEALS FROM PERPETRATORS [SECTION 26-3.1-108, C.R.S.]. In July 2018, statute began requiring the Program to provide perpetrators due process through an appeals process. As part of adjudicating the appeal, Program rules allow the Department to negotiate settlement agreements with perpetrators that modify, overturn, or remove the county findings from a CAPS check [Section 30.920.J, 12 CCR 2518-1]. If the Department upholds the county finding in an appeal, the finding on the perpetrator may be disclosed when an employer requests a CAPS check, depending on the settlement agreement. In Fiscal Year 2019, the Department managed 250 appeals related to adult protective services cases.

PROGRAM ADMINISTRATION AND FUNDING

At the state level, the Program is overseen by the Department's Division

of Aging and Adult Services. The Program has one program manager and 13 staff who provide technical assistance and training to county staff, monitor county compliance with statute and Program rules, process employer requests for CAPS checks, and administer CAPS. The Department's Administrative Review Division conducts quality assurance reviews of Program cases, and the Department's Child and Adult Mistreatment Dispute Review Section manages the appeal process for perpetrators. The State Board of Human Services promulgates rules for the Program.

In Fiscal Years 2019 and 2020, the Program received an average of $19.3 million in funding annually, averaging about $13.5 million in state general funds, $3.7 million in county matching funds, and about $2.1 million in federal funds from the Department's Title XX Social Services Block Grant. State and county funds are used for county staff salaries and benefits (89 percent), and the remaining funds are used for services for at-risk adults (6 percent) and Department-level administration of the Program (5 percent); federal funds are used for county administration. To receive federal block grant funding, federal regulations require the Department to report annually the number of individuals receiving services and the amount spent on each service; there are no other federal requirements for the Program [45 CFR 96.74].

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this performance audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of the state government, and Section 2-7-204(5), C.R.S., the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act. The audit was conducted in response to a legislative request that expressed concerns about the effectiveness of Program operations and Department oversight. Audit work was performed from July 2019 through May 2020. We appreciate the assistance provided by the management and staff of the Department of Human Services during this audit.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The objective of the audit was to evaluate the effectiveness of the Program in fulfilling its statutory purpose to provide for the safety and protection of at-risk adults and serve them in the least restrictive manner. This included evaluating county processes for screening reports of suspected mistreatment and self-neglect, investigating cases, and coordinating needed services, as well as assessing the Department's administration of CAPS checks for employers and appeals for perpetrators.

To accomplish our audit objective, we performed the following audit work:

- Reviewed applicable statutes, rules, and Department written guidance.
- Interviewed Department management and staff, supervisors and staff from 10 counties, 15 employers that serve adults with intellectual and developmental disabilities, and stakeholders including some caretakers of at-risk adults and advocates for people with disabilities.
- Analyzed CAPS data for Fiscal Years 2017 through 2020, as of March 31, 2020, including data on reports of mistreatment and self-neglect, investigations, substantiated findings, county notifications sent to substantiated perpetrators, service coordination, and county guardianships. Our audit work included analysis of live data in CAPS, and therefore the figures in this report may differ slightly from those reported by the Department previously.
- Analyzed Department data for the appeals that it managed and

notifications it sent appellants from July 2018 through December 2019, as well as the written appeals manuals used for these appeals.

- Reviewed the Program's written policies, guidance, and training documents provided to counties, and the results of Department desk reviews of county compliance with applicable requirements for Fiscal Year 2019 and quality assurance reviews of counties for Fiscal Years 2018 and 2019.
- Listened to archived audio recordings of legislative hearings for House Bill 17-1284, which created CAPS checks and the appeal process for perpetrators.
- Researched the adult protective services programs and laws in 20 other states.
- Reviewed the Department's SMART Government Act performance plans for Fiscal Years 2019 and 2020.

We relied on sampling techniques to support our audit work as follows:

- A random sample of 66 of the 25,001 reports of mistreatment and/or self-neglect that counties received in Fiscal Year 2019, which included CAPS case file data and hardcopy documentation for 21 reports screened out and 45 reports screened in, to assess county processes for screening reports and investigating cases.
- CAPS data and hardcopy documentation for all 145 reports of mistreatment and/or self-neglect for the six adults and six alleged perpetrators with the most reports submitted to counties during Fiscal Year 2019, to evaluate county processes for handling reports and cases for those individuals with the most reports annually.
- A random sample of 15 of the 58 permanent county guardianships of at-risk adults that began during Fiscal Year 2019, including CAPS case file data and hardcopy documentation, to evaluate county processes for petitioning the court for guardianship.
- A sample of 16 of the 87 appeals that were resolved by the Department in Fiscal Year 2019, including CAPS data and written settlement agreements, to evaluate the appeal process and the quality and consistency of appeal decisions. The sample included 12 appeals

that were randomly selected and the four appeals that took the longest amount of time to resolve.

The results of our nonstatistical samples cannot be projected to the population. However, the sample results are valid for confirming compliance with statute and rules, and along with the other audit work performed, provide sufficient, reliable evidence as the basis for our findings, conclusions, and recommendations.

As required by auditing standards, we planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Specifically, our work included the following internal control components and underlying principles based on guidance issued by the U.S. Government Accountability Office:

<table>
<tr><th colspan="2">SIGNIFICANT INTERNAL CONTROL COMPONENTS
AND UNDERLYING PRINCIPLES REVIEWED DURING THE AUDIT</th></tr>
<tr><td rowspan="2">Control Environment
Demonstrate Commitment to Integrity and Ethical Values
Exercise Oversight Responsibility
Establish Structure, Responsibility, and Authority
Demonstrate Commitment to Competence
Enforce Accountability</td><td>Control Activities
Design Control Activities
Design Activities for Information Systems
Implement Control Activities</td></tr>
<tr><td>Information and Communication
Use Quality Information
Communicate Internally
Communicate Externally</td></tr>
<tr><td>Risk Assessment
Define Objectives and Risk Tolerances
Identify, Analyze, and Respond to Risks
Identify, Analyze, and Respond to Change</td><td>Monitoring
Perform Monitoring Activities
Evaluate Issues and Remediate Deficiencies</td></tr>
<tr><td colspan="2">SOURCE: U.S. Government Accountability Office, Standards for Internal Control in the Federal Government (Green Book).</td></tr>
</table>

Our conclusions on the effectiveness of those controls that were significant to our audit objectives, as well as specific details about the audit work supporting our findings, conclusions, and recommendations, are described in the remainder of this report.

A draft of this report was reviewed by the Department, and we have incorporated its comments into the report where relevant. The written responses to the recommendations and the related implementation dates are the sole responsibility of the Department. However, in accordance with auditing standards, we have included Auditor's Addenda to Department responses that are inconsistent with the findings or conclusions.

CHAPTER 2
PROGRAM OPERATIONS

The General Assembly created the Adult Protective Services Program (Program), within the Department of Human Services (Department), to provide services to at-risk adults to help protect them from mistreatment and self-neglect [Sections 26-3.1-103 and 104, C.R.S.]. Our audit work evaluated the effectiveness of the Department's processes for administering Colorado Adult Protective Services system (CAPS) background checks for employers requesting them; managing appeals for perpetrators substantiated of mistreatment; and overseeing county processes for screening reports of mistreatment and self-neglect, investigating cases, and becoming guardians of at-risk adults. We identified problems in each of the areas that we reviewed and have

made recommendations for the Department to improve Program operations at the state and county levels with an overarching goal of improving protections for at-risk adults. Our audit work also identified a policy consideration for the General Assembly about whether the CAPS checks process, as established in statute, operates as well as it could to accomplish its purpose of helping ensure that people who have mistreated at-risk adults are not working directly with them.

CAPS BACKGROUND CHECKS

Counties use CAPS to document the results of their investigations and each finding of substantiated mistreatment of an at-risk adult. In this report, individuals substantiated of committing such mistreatment are referred to as "perpetrators." CAPS records note the type of mistreatment that occurred (i.e., physical abuse, sexual abuse, caretaker neglect, and/or exploitation); a summary of the investigatory evidence for a case, including the county's determination of whether the allegation was substantiated, unsubstantiated, or inconclusive; and the severity level of the mistreatment (i.e., minor, moderate, or severe), which is a measure of the harm to the at-risk adult's health, safety, welfare, and/or finances. According to rule, minor mistreatment results in minimal or no harm to the adult, moderate mistreatment is some harm, and severe mistreatment is substantial harm [Section 30.100, 12 CCR 2518-1].

In Fiscal Year 2019, counties substantiated 1,343 acts of mistreatment against at-risk adults in Colorado, and some perpetrators committed more than one act of mistreatment.

EXHIBIT 2.1 shows the mistreatment types and severity levels of each of these county findings in Fiscal Year 2019, along with the perpetrators' relationship to the at-risk adults that they mistreated.

EXHIBIT 2.1. FINDINGS OF MISTREATMENT BY TYPE, SEVERITY, AND RELATIONSHIP BETWEEN THE PERPETRATOR AND AT-RISK ADULT FISCAL YEAR 2019				
MISTREATMENT CATEGORY BY RELATIONSHIP TO AT-RISK ADULT	SEVERITY LEVEL			TOTAL
	MINOR	MODERATE	SEVERE	
PROFESSIONAL	**268**	**102**	**56**	426
Caretaker Neglect	184	76	33	293
Exploitation	49	13	20	82
Physical Abuse	26	13	2	41
Sexual Abuse	9	0	1	10
FAMILY OR COMMUNITY MEMBER	**451**	**304**	**145**	900
Caretaker Neglect	139	102	47	288
Exploitation	149	120	70	339
Physical Abuse	133	73	25	231
Sexual Abuse	30	9	3	42
UNKNOWN[1]	**5**	**8**	**4**	17
Exploitation	4	8	4	16
Sexual Abuse	1	0	0	1
TOTAL	724	414	205	1,343

SOURCE: Office of the State Auditor analysis of data from the Colorado Adult Protective Services system (CAPS).

[1] These findings involved instances of strangers committing the mistreatment such as financial exploitation of at-risk adults over the telephone.

The 1,343 acts of mistreatment in Fiscal Year 2019 were committed by 1,138 perpetrators. Of these, 326 (29 percent) were employed to provide direct care for the adults they mistreated; the remaining were family members of the mistreated adults (e.g., spouse, child, sibling) or community members (e.g., a fellow resident at a nursing home).

In 2017, the General Assembly passed House Bill 17-1284 to require certain employers that have direct care staff who work with at-risk adults, such as nursing homes and adult daycare facilities, to request that the Department conduct a CAPS check for all potential, new employees and contractors to determine if any have a substantiated perpetrator record in CAPS [Section 26-3.1-111(6), C.R.S.]. The Bill was passed out of concern that abusive caregivers could continue providing care for and potentially mistreat at-risk adults without consequence. During the Bill's legislative hearings, proponents stated

that a CAPS check process would limit direct service employees who commit mistreatment from being fired by one employer and simply being hired by another without the new employer knowing of the mistreatment. Proponents of the Bill emphasized that while direct caregivers may undergo criminal background checks, those checks would not report on employees' past mistreatment of at-risk adults unless there was a criminal conviction, which proponents reported rarely occurs.

When an employer requests a CAPS check, the Department notifies it if the potential employee has a substantiated finding that occurred on or after July 1, 2018, and was not made unreportable through an appeal [Sections 30.960(A) and (K), 12 CCR 2518-1]. In Calendar Year 2019, when the CAPS check process began, the Department conducted 109,066 CAPS checks for employers, and the checks identified 169 potential employees or contractors who were perpetrators.

WHAT AUDIT WORK WAS PERFORMED, WHAT WAS THE PURPOSE, AND HOW WERE THE RESULTS MEASURED?

We analyzed CAPS data from July 1, 2018, through December 31, 2019, to identify perpetrators that provided direct care to at-risk adults and the types and severity of mistreatment substantiated, and reviewed the requirements for the types of information the Department sends employers that request CAPS checks. We listened to audio recordings from House Bill 17-1284 hearings, and interviewed 15 employers in Colorado that serve adults with intellectual and developmental disabilities as well as Department, Program, and county management and staff. We reviewed the 2018 National Adult Protective Services Association's *Adult Protective Services Abuse Registry National Report* to understand laws, policies, and practices in 20 other states that have checks similar to the CAPS checks and researched the laws in eight of these states.

The purpose of the audit work was to determine whether CAPS checks,

which are most relevant for professionals who work with at-risk adults, help protect the adults in line with statutory intent to "minimize the potential for employment of persons with a history of mistreatment of at-risk adults in positions that would allow those persons unsupervised access to these adults" [Section 26-3.1-111(1), C.R.S.]. Specifically, we evaluated whether the information the Department provided to employers for CAPS checks requested in Calendar Year 2019:

- Was accurate and complete based on data about the finding in CAPS.

- Was sufficiently detailed to help employers evaluate the risks of hiring individuals who have worked with at-risk adults in the past. Statute permits the Department to disclose to employers "a report [of mistreatment] of an at-risk adult *and information relating to an investigation*…as part of a CAPS check" [emphasis added] [Section 26-3.1-102(7)(b)(VI), C.R.S.], and to define in rules what information will be provided [Section 26-3.1-111(5)(d), C.R.S.]. Department rules specify that it will provide an employer requesting a CAPS check the following: (1) date of the report of mistreatment, (2) county that completed the investigation, and (3) type and severity level of the mistreatment [Section 30.960(I)(4), 12 CCR 2518-1].

  Based on our audit work and interviews with the Department, counties, and employers, the type and severity of mistreatment that is substantiated by the counties ranges widely from accidental caretaker neglect of an at-risk adult resulting in no harm to intentional physical abuse of an at-risk adult resulting in severe harm. As such, our evaluation included considering whether the Department provides employers requesting CAPS checks with sufficient information to allow them to distinguish between one potential employee who has had an incident of intentional and serious mistreatment (such as physical and sexual abuse) and another potential employee with an isolated accidental incident of mistreatment (such as serving an at-risk adult burnt pancakes). Specifically, we evaluated whether the Department provided information to employers that included details as to what

mistreatment occurred, the actual harm to the at-risk adult, whether the mistreatment was intentional, and the relationship of the perpetrator to the at-risk adult.

WHAT PROBLEMS DID THE AUDIT IDENTIFY AND WHY DID THEY OCCUR?

Overall, the Department's CAPS check process could be improved to better achieve the intent of the law because the information provided to employers lacks sufficient detail that employers would need to make fully informed employment decisions, as described below.

LACK OF DETAIL IN CAPS CHECKS TO PROVIDE EMPLOYERS CONTEXT FOR SUBSTANTIATED MISTREATMENT. When responding to a request for a CAPS check on a potential employee or contractor, the Department does not inform the employer of details about any mistreatment, such as the actual harm that occurred, whether the mistreatment appeared intentional, or the relationship of the perpetrator to the at-risk adult who was harmed (e.g., whether the perpetrator was a paid professional, volunteer, or family member). The Department only reports the date and county where substantiated mistreatment took place, the type of mistreatment (i.e., physical abuse, sexual abuse, caretaker neglect, and/or exploitation), and the severity level (i.e., minor, moderate, or severe). The Department also provides employers with: (1) a brief standard description about county investigations, which cites the statutory requirements to investigate mistreatment, conclude if a preponderance of evidence shows that someone mistreated an at-risk adult, and maintain findings in CAPS, and states that findings may be used in making employment decisions; and (2) the definitions for each mistreatment type, the severity levels, and preponderance of evidence.

EXHIBIT 2.2 illustrates how the lack of detail about the mistreatment that is reported to employers through CAPS checks could be misleading.

EXHIBIT 2.2. EXAMPLES OF FINDINGS OF MISTREATMENT AND HOW THEY ARE REPORTED TO EMPLOYERS THROUGH CAPS CHECKS FISCAL YEAR 2019	
WHAT INCIDENT TOOK PLACE	WHAT WAS REPORTED TO THE EMPLOYER
Caretaker, who was an employee of a group home, served burnt pancakes to an adult who was unable to cook for themselves. There was no evidence of intent to harm or the adult experiencing harm.	Minor Caretaker Neglect
Nurse, who was a contractor for an assisted living facility, intentionally attempted to force-feed an adult medication, while yelling obscenities at the adult.	Minor Caretaker Neglect
Nurse, who was an employee at a nursing and rehabilitation center, intentionally kicked an adult in their care, with the adult reporting pain.	Minor Physical Abuse
Caregiver, who was an employee at a hospice facility, while assisting an adult in the shower, intentionally hit the adult with a towel, sprayed water in the adult's face, yelled obscenities, and flipped off the adult, with no visible harm to the adult.	Minor Physical Abuse
Employee at a memory care center, while assisting an adult in the shower, twice grabbed the hand of the adult when they jerked away from the water, causing pain and bruising on the adult's hand.	Moderate Physical Abuse
Caregiver, who was an employee at a nursing home, assisted an adult to move from a chair to a wheelchair, without the assistance from another caregiver as required, resulting in the adult's leg getting caught in the wheelchair and fracturing.	Severe Caretaker Neglect
Nurse, who was an employee at a nursing home, tipped an adult out of a wheelchair, then returned the adult to the wheelchair, without obtaining required assistance, resulting in pain and harm to the adult's arm, an arm splint, and orthopedic treatment.	Severe Physical Abuse
The daughter of the at-risk adult opened a $10,000 line of credit in the adult's name and deposited funds into her own bank account.	Minor Exploitation
Caregiver, who was an employee at a home health care agency, falsified time sheets by reporting more time worked than actually spent serving the at-risk adult.	Moderate Exploitation
Nurse, who is the niece of the at-risk adult, used $8,500 of the adult's funds without consent.	Severe Exploitation
SOURCE: Office of the State Auditor analysis of CAPS data.	

THE DEPARTMENT DOES NOT DIRECT COUNTIES TO DETERMINE INTENT AS PART OF THEIR INVESTIGATIONS. Since the statutory requirement for CAPS checks went into effect, the Department has required county investigations to determine: (1) if an allegation of mistreatment is substantiated based on a preponderance of the evidence; (2) the type of mistreatment; and (3) the severity level, and to enter into CAPS a

summary of evidence that supports each finding. According to the Department, it does not require counties to determine a perpetrator's intent when mistreatment occurs because there is no specific statutory requirement to determine intent and Department staff believe it would be subjective for counties to determine intent despite a preponderance of evidence. As a result, CAPS does not always contain information on whether the mistreatment was unintentional or intentional, meaning that this information would often be unavailable to provide to requesting employers in a CAPS check, should the Department provide employers with more information.

The Department said that it does not provide more information on each finding to employers during a CAPS check because statute does not specifically require it and it believes doing so could potentially violate an at-risk adult's privacy. However, the Department was not able to specify what privacy rights (e.g., what laws) it believes it would violate by reporting to an employer the type of information we found lacking, such as the actual harm that occurred, whether the mistreatment appeared intentional, and the relationship of the perpetrator to the at-risk adult who was harmed.

There are a number of ways that the Department could provide employers more information about mistreatment, in a manner that protects the privacy of the at-risk adult. First, the counties could draft a brief one-sentence summary of the mistreatment incident and whether it was intentional, similar to the descriptions that we developed in EXHIBIT 2.2, and provide them to employers during a CAPS check. The Department said that providing such a summary could cause delays in responding to employers requesting CAPS checks if the Department needed a legal review to ensure that confidential information is redacted from the summary in a manner that could be reported to employers. However, the Department could obtain clear legal guidance about what information can and cannot be included in a brief summary, and provide that guidance and training to counties, instead of having each summary reviewed by counsel.

Second, the Department could develop a process for employers to request more information about the mistreatment after receiving the current, standard CAPS check results. If such a process existed, the employer could decide whether the check provided enough information for making a hiring decision or could request additional information, such as a one-sentence summary of the mistreatment. Department management reported to us that it believes an employer can get more information by simply asking an applicant what happened in the incident. Nevertheless, having a process for employers to request from the Department additional information about a finding would ensure that employers receive unbiased and reliable information about the mistreatment.

A third method of providing meaningful information to employers would be to create additional categories that describe the mistreatment and can be reported in a CAPS check, in lieu of providing employers a brief synopsis of the mistreatment. Descriptive categories for mistreatment, in addition to the type and severity, could indicate whether the mistreatment was intentional or unintentional; the type of harm to the victim, if any (e.g., no harm, pain, bruising, fracture, life-threatening injury); the type of exploitation committed (e.g., financial scam using an at-risk adult's funds for the perpetrator's benefit); and the relationship between the perpetrator and person they mistreated (e.g., professional, familial relationship, community). For example, in the case cited in EXHIBIT 2.2 where a nurse, who was an employee at a nursing and rehabilitation center, intentionally kicked an adult in their care resulting in the adult experiencing pain, the CAPS check report could indicate that there was intentional minor physical abuse by a professional causing pain but no further injury to the adult. According to Department management, it does not believe that employers should be informed about the relationship between the applicant and at-risk adult because a CAPS check showing that the applicant mistreated their own family member could give the employer a false sense of security in hiring the perpetrator.

Some other states that have similar checks for adult protective services

provide employers with contextual information to help them make informed hiring decisions. For example:

- Arizona maintains an online registry that summarizes the details of each finding, the perpetrator's name and date of birth, and the date that the finding was placed on the registry. Employers, and any member of the public, can see the name of the perpetrator, whether the perpetrator is a professional, and a short description of the incident such as: the provider got into an altercation with an at-risk adult and did not follow the adult's care plan, which resulted in injury to the adult.

- In New Jersey, the checks report on mistreatment that is intentional, reckless, or committed with careless disregard and committed by someone in a professional setting.

- In New Hampshire, if an employer receives notice that an applicant is a perpetrator, the employer can, with the applicant's permission, request more information about the substantiation from the state's adult protective services department.

- In Oklahoma, the perpetrator registry provides employers with information about mistreatment committed by community service workers and personal care assistants, such as an employee working in a Medicaid-funded program, so that employers know that there was a professional relationship between the perpetrator and the at-risk adult they mistreated.

These examples provide a variety of options that the Department could implement to improve the quality of information that Colorado employers receive in a CAPS check.

WHY DO THESE PROBLEMS MATTER?

The lack of sufficiently detailed information reported through a CAPS check can result in employers hiring or contracting with an individual who is a danger to at-risk adults, which increases the potential for abuse of this population. For example, if an employer received employment

applications from the two individuals who committed the mistreatment in the first two case examples shown in EXHIBIT 2.2, the employer would receive CAPS checks that showed: (1) one prospective employee had committed "minor caretaker neglect" in a particular county on a certain date, without any other detail, and not that the incident involved an individual unintentionally serving burnt pancakes to an adult; and (2) another prospective employee had committed "minor caretaker neglect" without more detail, and not that the perpetrator forcefully opened an adult's mouth and attempted to force-feed them medication, while yelling obscenities. Thus, the employer would likely consider each of these applicants as having committed similar acts, even though the mistreatment in each case was very different.

When employers do not receive sufficiently detailed information through a CAPS check, it could also lead them to refuse employment to an individual who poses no, or very low, risk, which would reduce the pool of qualified individuals serving at-risk adults. Some employers that testified during the 2017 legislative hearings and some that we interviewed during this audit indicated that they likely would not hire an applicant with any substantiated finding of mistreatment reported in a CAPS check. For example, the perpetrator mentioned previously who had served an adult burnt pancakes, may be denied employment because an employer would not understand the nature of the incident. However, if employers were provided more information, such as some explanation of the incident, whether it was intentional, whether the adult was actually harmed, and whether the perpetrator was a professional in the field, employers would be able to make more nuanced decisions. Some large Colorado employers with about 200 employees who care for at-risk adults told us that they would find it helpful to have a brief synopsis of the mistreatment to make informed hiring decisions.

Further, if employers are short-staffed and the only qualified applicants for job openings in their areas of the state are perpetrators substantiated for minor caretaker neglect, the employers may not have enough context from the CAPS checks to make hiring decisions that are in the

best interest of the at-risk adults they serve. During our 2018 performance audit of the 20 Community-Centered Boards (CCBs), which provide direct care to thousands of at-risk adults in Colorado, most CCBs told us that they face ongoing shortages of direct care staff, which can make finding qualified applicants a challenge. As time goes by, it is likely that more perpetrators will become permanently reportable in a CAPS check, which could limit employers' hiring options if they plan to deny all applicants whose names are reported in a CAPS check. The health and safety of at-risk adults could be at stake if they receive services from employers that are understaffed and staff are unable to meet the needs of all of the at-risk adults in their care, or if necessary services become unavailable due to staff shortages. There is a risk that eventually, some employers may be more willing to hire perpetrators due to a lack of qualified applicants and a lack of context to explain the mistreatment that occurred.

RECOMMENDATION 1

The Department of Human Services (Department) should implement a policy and process to improve the descriptive information about substantiated findings of mistreatment of at-risk adults that is reported to employers through checks of the Colorado Adult Protective Services system (CAPS). This process could include providing employers that request a CAPS check with a brief finding summary that excludes confidential and protected information, allowing employers to request more information about the finding from the Department after a CAPS check, and/or developing and reporting to employers descriptive categories for findings of mistreatment that better reflect the range of incidents that occur including whether there was actual harm or intent, and the relationship of the perpetrator to the at-risk adult.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

PARTIALLY AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department agrees to consider the merits of this recommended policy and process change by engaging in a thoughtful and methodical approach to assess the advantages and disadvantages, including the feasibility and cost, of providing descriptive information to employers as part of CAPS check results. Without adequate research, analysis, and having the opportunity to discuss this recommended policy change with key stakeholders, it is currently unclear to the Department if this is a sound policy decision. Therefore, the Department cannot agree to implement this policy change at this time. Once the necessary research, analysis and outreach are completed, the Department will determine whether or not it will request a rule change from the State Board of Human Services to implement this policy and process change.

AUDITOR'S ADDENDUM

The audit found that the Department's CAPS checks do not provide employers with sufficient information about a perpetrator's mistreatment of at-risk adults. When insufficient descriptive information is reported to employers, it can result in them hiring or contracting with an individual who is a danger to at-risk adults or refusing employment to an individual who poses no or very low risk to at-risk adults. Providing sufficient descriptive information to employers would help them make more informed employment decisions.

POLICY CONSIDERATIONS RELATED TO CAPS CHECKS

The General Assembly's intent for the CAPS check statute, pursuant to House Bill 17-1284, was to enhance protections for at-risk adults by helping ensure that perpetrators are not working directly with them. During the audit, we reviewed the CAPS check processes implemented by the Department to carry out House Bill 17-1284 and assessed how the checks work in practice. The sections of this report titled "CAPS Background Checks" and "Outcomes of Appeals for Perpetrators" explain the problems that we identified with the processes that the Department implemented in July 2018 and January 2019, which can lessen the effectiveness of CAPS checks. Our audit work also identified aspects of the CAPS check process that may not provide adequate protection for at-risk adults and that are beyond the authority of the Department. These are issues that the General Assembly may want to consider addressing to strengthen CAPS checks such that they enhance safeguards for at-risk adults. This is a matter for policymakers to consider, and therefore, we issue no recommendations in this section.

WHAT POLICY ISSUES DID THE AUDIT IDENTIFY?

According to statute, CAPS checks should "minimize the potential for employment of persons with a history of mistreatment of at-risk adults in positions that would allow those persons unsupervised access to these adults" [Section 26-3.1-111(1), C.R.S.]. Statute:

1 Requires certain employers that directly serve at-risk adults, such as community-based providers, nursing homes, and long-term care facilities, to request that the Department check CAPS to obtain information about any county findings of substantiated mistreatment by a potential new employee or contractor being considered for positions working directly with at-risk adults, and

2 Allows these employers to deny employment based on the information obtained through a CAPS check [Section 26-3.1-111, C.R.S.].

In practice, CAPS checks are not working as effectively as they could to protect at-risk adults. We identified some policy areas that the General Assembly might want to consider that could help further protect at-risk adults through the check process.

EMPLOYERS CAN CONTINUE HIRING AND EMPLOYING PERPETRATORS

In 2017, when the General Assembly passed House Bill 17-1284 to require certain employers to request CAPS checks for all potential, new employees and contractors, discussion at the bill hearings focused on concerns with employers hiring individuals whose accusations of mistreatment had already been substantiated to work directly with at-risk adults. For example, legislators, Department staff, and stakeholders raised concerns about an employee who severely mistreated at-risk adults at the Department's Pueblo Regional Center, who was terminated, not convicted of any criminal action related to the mistreatment, but was able to obtain a new job caring for at-risk adults. Based on the hearing discussion, the CAPS check process was intended to prevent this type of situation. However, the bill does not prohibit employers from hiring known perpetrators. The lack of any prohibition may be due to testimony by proponents of the bill, including the Department, that it was likely that employers would not hire perpetrators upon learning of the results of CAPS checks and therefore, a prohibition was not considered necessary. As a result, statute permits an employer to hire, continue to employ, or contract with someone identified as a perpetrator through a CAPS check. The General Assembly might want to consider whether allowing employers to knowingly hire perpetrators achieves the overall statutory intent of protecting at-risk adults.

We could not determine the extent to which CAPS checks limit the

number of perpetrators hired for these types of positions because the Department does not track how many or which substantiated perpetrators are hired to provide direct care for at-risk adults. However, during our audit, one employer expressed concerns about another employer which provided direct care to at-risk adults and had hired a perpetrator whose severe mistreatment of an at-risk adult had been substantiated. Considering that there were 326 direct care professionals who committed 426 acts of mistreatment in Colorado in Fiscal Year 2019 alone, and that the CAPS checks do not provide employers with sufficient detail about mistreatment findings, there is an ongoing risk that these professionals could move from one direct care employer to another and continue to interact with at-risk adults directly. We identified examples of this type of situation during the audit. Two professionals who worked with at-risk adults at a nursing home had been substantiated of intentionally ignoring their employer's procedure to regularly check on the at-risk adults in their care. As a result, an adult suffered life-threatening injuries that went unattended for hours. After these allegations of severe mistreatment were substantiated, one perpetrator continued to be employed at the facility where the mistreatment occurred. The other perpetrator was terminated by the employer but may have been able to gain employment working with at-risk adults at another facility since there is no prohibition against perpetrators continuing to work with at-risk adults.

We identified 12 other states that have some type of prohibition against hiring known perpetrators for positions that provide direct care to at-risk adults: Hawaii, Illinois, Iowa, Minnesota, Missouri, New Hampshire, New Jersey, Ohio, Oklahoma, Tennessee, Texas, and West Virginia. We identified five states—Iowa, Minnesota, New Jersey, Ohio, and Tennessee—that require employers to fire perpetrators employed at the time of the substantiation of mistreatment, and two states—Illinois and Oklahoma—that prohibit state funds from being used to employ known perpetrators, effectively preventing employers that receive public funds from employing them.

POLICY CONSIDERATION. If the General Assembly decides that legislative

change is needed in this area, it may want to consider implementing some type of prohibition against hiring or employing known perpetrators for positions that provide direct care to at-risk adults. This could include prohibiting certain direct care employers from employing specific types of known perpetrators, such as direct care workers who committed intentional or repeated severe mistreatment against at-risk adults. This could also include prohibiting the use of public funds to knowingly hire or employ for such direct care positions any perpetrators who intentionally or repeatedly commit severe mistreatment of at-risk adults.

CURRENT EMPLOYEES ARE NOT REQUIRED TO HAVE CAPS CHECKS

While the Department and some employers we interviewed told us that employers sometimes conduct CAPS checks on all employees, and not just new hires, statute [Section 26-3.1-111, C.R.S.] only requires potential *new* employees to undergo CAPS checks. The risk of an employer being unaware of an employee's substantiated mistreatment of an at-risk adult may be higher in some circumstances than others. For example, it may be more difficult for an agency overseeing host homes to monitor whether there are investigations of employees at the individual host homes than it would be for a small nursing home. Currently, neither the counties nor the Department notify employers when a county substantiates that an employee has mistreated an at-risk adult, unless (1) the employer initiates a CAPS check on that employee, or (2) after the employer's CAPS check, the employee is substantiated for mistreatment, in which case the Department would contact the employer, confirm the perpetrator still works there, and notify the employer of the subsequent substantiation.

We identified 152 perpetrators in CAPS, who were substantiated for mistreatment after July 1, 2018, and were professionals working with at-risk adults but have not undergone a CAPS check, which indicates that they have not changed employment since July 2018. In the event that an employer requested a CAPS check on these individuals, the

employers would be informed of the finding. However, without initiating a check, agencies that employ these 152 perpetrators may be unaware that they have employees who have harmed at-risk adults.

We found that some states (Delaware, Illinois, Maine, Missouri, New Jersey, Oklahoma, and Texas) have processes to report to employers the findings of mistreatment committed by their current employees, without requiring the employers to request a check.

POLICY CONSIDERATION. If the General Assembly decides that legislative change is needed in this area, it may want to consider requiring employers to conduct CAPS checks on existing employees who work directly with at-risk adults. Alternatively, the General Assembly may want to consider requiring the Department proactively report to direct care employers the findings of mistreatment committed by their current employees, without requiring the employers to request a check.

NO CAPS CHECKS FOR THOSE PETITIONING FOR GUARDIANSHIP OR CONSERVATORSHIP FOR AT-RISK ADULTS

Currently, statute does not authorize courts to conduct CAPS checks on people who petition the court for legal authority (such as through a guardianship or conservatorship) over at-risk adults. Allowing or requiring courts to conduct such checks could expand the protections the CAPS check process is intended to provide to at-risk adults.

As of May 2020, the General Assembly was considering House Bill 20-1302, which if passed in its current form, would expand the requirement for requesting CAPS checks to the newly formed Office of Public Guardianship, meaning any person *hired* by that office to become a guardian would undergo a CAPS check. All other entities and individuals who petition for a guardianship of an at-risk adult would not be subject to a CAPS check under this bill.

POLICY CONSIDERATION. If the General Assembly decides that legislative change is needed in this area, it may want to consider authorizing the

Colorado judicial system to request CAPS checks from the Department on individuals petitioning the courts for legal authority of at-risk adults and authorizing the Department to report the results of CAPS checks to requesting courts.

NO NOTIFICATION TO LICENSING OR CERTIFICATION ENTITIES WHEN PROFESSIONALS MISTREAT AT-RISK ADULTS

Currently, statute does not authorize licensing and certification agencies to be informed when a professional, who they have licensed or certified to work with at-risk adults, is substantiated for mistreatment of such adults. For example, if a licensed nurse in Colorado is found to have mistreated an at-risk adult under their care, the Department cannot inform the Colorado Board of Nursing, within the Department of Regulatory Agencies, of the finding. The Colorado Board of Nursing issues nursing licenses and could consider mistreatment of at-risk adults as grounds for discipline if a nurse "willfully or negligently acted in a manner inconsistent with the health or safety of persons under his or her care" [Section 12-255-120(1)(c), C.R.S.]. At least nine states (Hawaii, Kansas, Minnesota, Missouri, Nebraska, New Jersey, Ohio, Oklahoma, and Texas) require their adult protective services departments to proactively notify licensing and certification agencies when such individuals are substantiated for mistreatment of at-risk adults so that the entities can decide whether to revoke the licenses and certifications of the perpetrators.

POLICY CONSIDERATION. If the General Assembly decides that legislative change is needed in this area, it may want to consider requiring the Department to proactively notify licensing and certification agencies when a professional that they have licensed or certified to work with at-risk adults is known to have mistreated such adults.

ALL MINOR ISOLATED OR UNINTENTIONAL FINDINGS NOT EXCLUDED FROM CAPS CHECKS

All substantiated findings, regardless of their nature, are reported to employers through CAPS checks, unless they are made unreportable based on an appeal. We found some states exclude isolated findings of minor mistreatment from being reported through adult protective services checks. For example, in Iowa and Maine, substantiated findings of mistreatment are categorized as non-reportable if the mistreatment was minor, isolated, and unlikely to reoccur, unless the perpetrator committed similar mistreatment within a set timeframe (5 years in Iowa and 9 months in Maine). In New Jersey, the only findings reportable to employers are those where the perpetrator committed (1) abuse "with intent, recklessness, or careless disregard to cause or potentially cause injury;" (2) caretaker neglect "with gross negligence, recklessness, or in a pattern of behavior that causes or potentially causes harm;" or (3) financial exploitation above a certain dollar amount. Similar parameters in Colorado could help ensure that perpetrators who committed severe, intentional, knowing, and/or reckless, mistreatment are known to employers while reducing the chance that persons whose actions unintentionally resulted in minor mistreatment will be denied employment. For example, we identified a finding where a caretaker at a facility was assisting one at-risk adult in the bathroom when another at-risk adult walked out of the facility and returned within minutes, uninjured. Excluding this type of finding from being reportable, particularly in the absence of any repeated findings about the perpetrator after a period of time, could help strengthen the protections the check offers by focusing on more egregious incidents of mistreatment.

Currently, statute does not specify whether the Department can omit certain types of findings from being reported in a CAPS check, as is allowed for background checks for the Department's Child Welfare Program. Under Section 19-3-309.5, C.R.S., counties can make a finding unreportable to employers, at least for a period of time, when: (1) the perpetrator has no prior allegations of abuse against a child, (2)

the abuse was minor, and (3) the perpetrator and county agree on a plan to ensure the child's safety and the perpetrator implements the plan within 60 days.

POLICY CONSIDERATION. If the General Assembly decides that legislative change is needed in this area, it may want to consider authorizing the Department to exclude isolated unintentional findings of minor mistreatment from being reported through CAPS checks. This could include allowing or requiring the Program to implement a process that requires perpetrators to take preventive actions following the mistreatment to help ensure the health and safety of at-risk adults.

We provided these policy considerations to the Department for its review and feedback. In general, the Department told us that it did not have a position on these considerations but offered background on why some of these considerations have not been addressed. According to the Department, House Bill 17-1284 did not address some of these policy considerations because of associated costs and fiscal note implications, and in 2017, some employers had raised concerns with the possibility of not being allowed to hire perpetrators and with the potential resources needed to conduct CAPS checks for current employees. We recognize that in contemplating policy changes to make CAPS checks more robust, the General Assembly would need to consider the impact of such changes on the Department and employers.

OUTCOMES OF APPEALS FOR PERPETRATORS

House Bill 17-1284 required the Department to establish a process for perpetrators who have been substantiated by a county investigation of having mistreated an at-risk adult, to appeal the county findings [Section 26-3.1-108(2), C.R.S.]. The appeal process began on July 1, 2018. Substantiated findings of mistreatment are reportable to employers through a CAPS check indefinitely unless perpetrators appeal and the outcome of the appeal either reduces the amount of time that the finding is reportable or makes a finding unreportable. Program rules specify that a perpetrator can appeal based on one of two grounds: (1) the county's findings are *not* supported by a preponderance of credible evidence or (2) the acts committed by the perpetrator *do not* meet the definition of mistreatment in statute or rule [Section 30.920(B), 12 CCR 2518-1]. A perpetrator who submits an appeal is referred to as an "appellant."

The Department's Child and Adult Mistreatment Dispute Review Section processes appeals for adult protective services. In Fiscal Year 2019, four Department staff reviewed appeals and they were overseen by one supervisor. Appeal reviewer responsibilities include reviewing documentation from the county and the appellant about the case, determining whether to uphold or overturn the county's findings, negotiating for settlement with the appellant for upheld decisions, and tracking each appeal in a spreadsheet and hardcopy files.

According to Program rules [Section 30.920(J), 12 CCR 2518-1], an appealed case can have one of the following outcomes:

- **UPHELD**, meaning the Department agrees with the results of the county's investigation and upholds the finding that mistreatment occurred and a preponderance of evidence supports the finding. Rule authorizes the Department to enter into settlement negotiations with the appellant as part of the litigation process.

- **OVERTURNED**, meaning the Department disagrees with the county's finding that mistreatment occurred and overturns it because there is not a preponderance of evidence to support it, new evidence emerges that refutes the finding, or the act committed was not mistreatment of an at-risk adult. If a county's decision is overturned, the alleged mistreatment is not reported in a CAPS check, although information about the county's original finding and the appeal remains in CAPS and accessible to county caseworkers.

- **FORWARDED TO THE OFFICE OF ADMINISTRATIVE COURTS (ADMINISTRATIVE COURTS) FOR A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE.** An appeal goes to the Administrative Courts under two scenarios: (1) the Department upholds the finding, makes initial contact with the appellant, loses contact with the appellant, and cannot finalize a settlement within 120 days of the appeal date; or (2) the Department upholds the finding but is unable or unwilling to negotiate a settlement agreement, and the appellant chooses to pursue the appeal through a hearing. Administrative Courts decide whether to uphold, modify, or overturn the county's finding of mistreatment, or can ask the appellant to reattempt a settlement with the Department.

If an appellant submits an appeal but cannot be contacted by the Department at all within 120 days, or the appellant withdraws their appeal, the appeal is tracked in CAPS as abandoned by the appellant, and the county finding of mistreatment is upheld [Section 30.920(N), 12 CCR 2518-1].

In Fiscal Year 2019, our review period of appeal outcomes, the Department received 250 appeals and resolved 87 of them (35 percent), as shown in EXHIBIT 2.3. Of the remaining 163 appeals, 152 were still going through the appeal process with the Department and 11 were going through the Administrative Courts' process, as of the end of Fiscal Year 2019.

EXHIBIT 2.3. ADULT PROTECTIVE SERVICES APPEALS RESOLVED BY THE DEPARTMENT FISCAL YEAR 2019		
RESOLVED APPEALS	NUMBER OF APPEALS	PERCENTAGE OF APPEALS
Upheld by Department	80	92%
Abandoned by Appellant	3	3%
Overturned by Department	4	5%
TOTAL	87	100%
SOURCE: Office of the State Auditor analysis of CAPS data.		

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS THE PURPOSE?

For a sample of 16 of the 87 appeals resolved in Fiscal Year 2019, we analyzed the data in CAPS and the Department's appeals spreadsheet and hardcopy files, including written settlement agreements with appellants. The sample included 12 randomly selected appeals and the four appeals that had been open the longest without being resolved. We reviewed data in CAPS that reflected information reported to employers through CAPS checks in Calendar Year 2019. We interviewed Department management who oversee the staff who review appeals and Program management and staff, and reviewed the 2018 and 2019 versions of the Department's appeals manual. We also reviewed the Department's SMART Government Act performance plans from Fiscal Years 2019 and 2020 [Section 2-7-204(3)(a)(I), C.R.S.], and did not find any performance measures related to the Child and Adult Mistreatment Dispute Review Section or the appeal process.

The purpose of our work was to evaluate the Department's adherence to statute and rules related to appeals, the quality and consistency of the appeal decisions, and the Department's adherence to internal control requirements related to appeals.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED

We reviewed the appeal process to determine the extent to which it is

designed and operating to achieve the Program's primary duty of protecting at-risk adults, while also providing due process to perpetrators. In particular, we attempted to assess the extent to which appeal reviewers considered the factors cited in rule and the appeals manual when deciding the outcome of an appeal, including what conditions to include in settlement agreements. First, when attempting to resolve an appeal, rule [Section 30.920(J), 12 CCR 2518-1] and the *Decision-Making and Considerations* section of the Department's appeals manual list the following items that "will be considered" by appeal reviewers:

- The best interests of at-risk adults,
- The weight of the evidence,
- The severity of the mistreatment,
- Any patterns of mistreatment reflected in the record,
- The results of any court processes,
- The rehabilitation of the appellant, and
- Any other pertinent information.

Second, when the Department upholds a finding, the appeals manual states that appeal reviewers are to explain to appellants the benefits of settlement, as opposed to taking appeals to an Administrative Courts hearing, and negotiate settlements for upheld appeals unless a settlement is "deemed not appropriate." The appeals manual lists items that reviewers are to consider for "exploration" when determining a settlement, to the extent that these are applicable to the case, as follows:

- The type of abuse and severity of the incident,
- The appellant's role in the incident and whether it was an isolated event or part of a pattern of behavior,
- The appellant's history (in CAPS) with social services and criminal courts,

- Current court processes based on the incident,
- The appellant's response to the incident and demonstration of control over their behaviors,
- Whether the appellant has realistic expectations of the victim and acts in a positive manner toward them,
- Whether the appellant made adjustments to provide for the needs of the victim, such as changes to the victim's living environment or conditions,
- The appellant's ability to care for the victim or other at-risk adults in a safe way, and
- The risk of a similar incident reoccurring in the future.

The appeals manual does not contain further guidance on any of the bulleted items or suggest when a settlement agreement is not appropriate, such as when there are indicators that the appellant is and may continue to be a threat to at-risk adults. In the absence of specific guidance, we reviewed for any documentary evidence that these factors were considered by the appeal reviewers, and that such consideration influenced the reviewers' decisions.

We also assessed whether the Department's appeal processes align with the U.S. Government Accountability Office (GAO) *Standards for Internal Control in the Federal Government*) (Green Book). Internal controls are processes implemented by management to provide reasonable assurance that the objectives of the agency will be achieved. All state agencies are required to follow Green Book standards. We focused on the Department's application of the following standards:

- "Documentation is required for the effective design, implementation, and operating effectiveness of an entity's internal control system" [Green Book, OV4.08].
- Management should maintain information that is complete, appropriate, relevant, and accessible to make informed decisions,

address risks, and ensure objectives are being met [Green Book, Principle 13].

- Documentation "provides a means to retain organizational knowledge and mitigate the risk of having that knowledge limited to a few personnel" [Green Book, 3.10].

Consistent with these standards, the Committee of Sponsoring Organizations of the Treadway Commission (COSO), which provides guidance on internal control to improve organizational performance and governance, has underscored that controls cannot be performed entirely in the minds of staff without some documentation of the thought process and analysis.

WHAT PROBLEMS DID THE AUDIT IDENTIFY AND WHY DO THEY MATTER?

The appeal process is not designed or operating as well as it could to protect at-risk adults. Specifically, the Department's requirements, processes, and decisions related to settlement agreements for upheld appeals appear to place the interests of substantiated perpetrators of mistreatment above the interests of the at-risk population. We identified the following ways in which the appeal process undermines the protection of at-risk adults provided by the Program.

SETTLEMENTS RESULT IN MISTREATMENT GOING UNREPORTED OR MISREPORTED IN CAPS CHECKS. Of the 80 appeals that the Department upheld in Fiscal Year 2019, it entered into settlement agreements 78 times (98 percent), all of which resulted in the substantiated mistreatment becoming *unreportable* in a CAPS check. This means that when an employer requests a check of CAPS, the system does not inform them that the appellants in these cases had mistreated an at-risk adult.

EXHIBIT 2.4 shows the severity level and type of caregiver for the 78 appeals that resulted in the mistreatment becoming unreportable in a CAPS check.

EXHIBIT 2.4. APPEALS THAT EXEMPTED APPELLANTS FROM CAPS CHECK REPORTING FISCAL YEAR 2019					
CATEGORY OF CARETAKER	SEVERITY OF MISTREATMENT				PERCENTAGE
	MINOR	MODERATE	SEVERE	TOTAL	
Professional	32	9	7	48	62%
Family or Community Member	18	10	2	30	38%
TOTAL	50	19	9	78	100%

SOURCE: Office of the State Auditor analysis of data from CAPS.

- **UPHELD FINDINGS ARE MADE UNREPORTABLE IMMEDIATELY.** For 57 of the 78 appeals (73 percent), the change in reportability went into effect *immediately*. For example, the settlement agreements made the mistreatment unreportable in a CAPS check immediately for six professionals whom the Department upheld as having severely mistreated the at-risk adults in their care. These examples included:

  - A provider deliberately not checking on at-risk adults in their care for 4 hours and instead spending that time in a television room, which resulted in the provider not attending to or seeking medical care for an at-risk adult who had a broken hip, shoulder pain, and a hematoma on the head, leaving the adult in pain for hours. Eventually, another staff member found the resident and sought medical assistance, resulting in the adult's hospitalization.

  - A host home provider waiting 4 hours to call poison control and 911 after an at-risk adult consumed another adult's medication, resulting in the at-risk adult overdosing and suffering multiple organ failure. The appellant claimed the delay in calling 911 occurred because they did not know that the adult consumed the medication. However, the case file in CAPS showed that the appellant's employer, a police detective, and a county caseworker believed the act was deliberate, particularly since the appellant first called poison control instead of 911.

  - A caretaker deliberately denying transportation services to an at-risk adult who needed to attend a court hearing, which resulted in the court eventually jailing the at-risk adult for 30 days. The

case file in CAPS showed that the appellant reported not feeling safe transporting the at-risk adult, but the appellant's employer said there had been no safety issues transporting the adult and had told the appellant they could arrange alternate transportation, which the appellant did not do. The case file showed the appellant was aware that by denying transportation services, the at-risk adult would go to jail, and the appellant said that the adult was "better off in jail."

The Department also made the mistreatment unreportable *immediately* for six other professionals who were upheld for moderate mistreatment, such as not providing adequate medical or nutritional care to at-risk adults.

- **UPHELD FINDINGS ARE MADE UNREPORTABLE WITH A TIME DELAY.** In the remaining 21 of 78 appeals with settlement agreements (27 percent), the change in reportability went into effect after a period of time; the appellants' names remained reportable to employers in a CAPS check for 1 year or more after the settlement agreement and then became unreportable. For example, in an appeal where an adult day program supervisor was substantiated for minor mistreatment of an at-risk adult because they incorrectly allowed staff to leave the adult unsupervised, which resulted in the adult leaving the facility without staff noticing and the supervisor being placed on corrective action by the employer. The settlement agreement made this mistreatment reportable for 1 year, and then unreportable if no mistreatment occurred during that 1 year. In these 21 appeals, if the appellants are substantiated for mistreatment again within the settlement agreement timeframe, they may appeal the new finding; if an appeal is not sought or does not result in the finding being overturned, both the initial finding and the new finding are reportable in a CAPS check. If the appellants are substantiated for mistreatment *after* the settlement agreement timeframe expires, only the new finding of mistreatment would be reportable in a CAPS check and the initial finding would remain unreportable.

- **UPHELD FINDINGS ARE CHANGED OR DOWNGRADED.** We found that

in 14 cases, the Department upheld the county's finding about the type of mistreatment (i.e., physical abuse, sexual abuse, caretaker neglect, and/or exploitation) and the severity (i.e., minor, moderate, or severe), but changed either the type or severity of mistreatment that would be reported in a CAPS check. With respect to severity, in all cases the Department reduced the level that would be reported (e.g., from severe to moderate or moderate to minor). For example, in seven appeals, the Department upheld that the appellants had committed severe mistreatment, including caretaker neglect and financial exploitation, but downgraded the severity level that would be reported to employers in a CAPS check to moderate.

The Department's practice of making a county's finding of mistreatment unreportable after having upheld the finding undermines the legislative intent of the CAPS checks and instead negates the protections the check process is intended to offer at-risk adults. According to Department management, a CAPS check is to inform employers about a perpetrator's history. Yet, as a result of the settlement process created by the Department, most appeals it upholds (98 percent in Fiscal Year 2019) result in the appellants no longer having their names reportable in a CAPS check at some point, meaning that they can seek new jobs to work directly with at-risk adults, without consequence. This practice likely leads to employers hiring substantiated perpetrators to work with at-risk adults because the information they receive through a CAPS check has been modified based on a settlement agreement and employers would not be informed that they mistreated at-risk adults. For 20 of the employer CAPS checks conducted in Calendar Year 2019, the checks did not report to the employers that the potential employee or contractor being checked had been substantiated of mistreating at-risk adults because the Department made the findings unreportable after upholding them on appeal. By contrast, 270 CAPS checks reported to employers that potential employees or contractors had been substantiated of mistreatment in 109,066 CAPS checks conducted that year.

Furthermore, determining the reportability of a finding based on whether a perpetrator appeals it, is both reactive and inequitable. In our

review of 20 other states' policies related to reporting findings of mistreatment of at-risk adults, we did not identify any that use this type of passive approach. For example, by rule, Kentucky makes all findings of minor mistreatment reportable for a minimum of 7 years and all findings of severe mistreatment resulting in a fatality or near fatality are reportable permanently. Missouri makes all substantiated findings reportable for at least 6 months with some being reported permanently, depending on the type and severity of mistreatment. New Hampshire makes findings reportable up to 7 years, depending on the type and severity of mistreatment. Under New Jersey law, a perpetrator's mistreatment is reportable for 5 years, after which they can apply to make their name no longer reportable if they demonstrate with clear and convincing evidence that they have been rehabilitated. None of these states change a substantiated finding from reportable to unreportable because of an appeal.

Settlement agreements did not always attempt to prevent further mistreatment of at-risk adults. We found that 15 of the 78 appeals with settlement agreements in Fiscal Year 2019 (19 percent) did not place any conditions on the appellant; in these 15 cases, the Department made the appellant's record unreportable in a CAPS check, despite the substantiated mistreatment, without requiring the appellant to change their behavior in any way. Eight of these 15 were professional caregivers and one of the 15 had been substantiated of moderate mistreatment. For example, the settlement agreement for the professional who was substantiated for moderate mistreatment did not include a condition that the appellant refrain from any further mistreatment, but the Department made the substantiated finding permanently unreportable in a CAPS check. In these 15 cases, not only did the settlement agreements result in information reported to employers being inaccurate because appeal reviewers modified CAPS to reflect that there was no substantiated finding, the Department failed to take action to protect at-risk adults by requiring improved behavior by the appellant. For the other 63 upheld appeals with settlement agreements, the agreements required the appellants to refrain from further mistreatment of at-risk adults for varying periods of time; if the

appellants do not meet this requirement, the findings will become reportable through a CAPS check.

When settlement agreements do not include conditions to help prevent known perpetrators from committing further mistreatment, and make information unreportable through a CAPS check, it can result in further harm to at-risk adults and renders the CAPS check process ineffective. In our review of 20 other states, we did not identify *any* state that makes upheld findings unreportable without conditions.

Lack of consistency in settlement agreements. We could find no consistent basis for the conditions, or lack thereof, in the settlement agreements we reviewed. For example, we found one case in our sample of 16 where the Department upheld a county's finding that an individual had committed *moderate* financial exploitation of an at-risk adult, but made the finding immediately and permanently unreportable in a CAPS check. By contrast, we found two cases where the Department upheld the county's findings of *minor* caretaker neglect, but, as a condition of a settlement agreement, required the appellant to avoid any further mistreatment for between 39 and 53 months, after which the findings would be made permanently unreportable.

We also reviewed three settlement agreements established in February 2020 that were not in our sample, all of which required the appellants to refrain from further mistreatment for specified periods in exchange for making the findings unreportable through CAPS. We found no correlation between the type or severity of the findings and the period of time the appellants were expected to avoid mistreatment. One involved minor caretaker neglect and made the findings unreportable in a CAPS check as long as the appellant avoided further mistreatment for 1 year; another was also minor caretaker neglect and made the findings unreportable in a CAPS check as long as the appellant avoided further mistreatment for 3 years; the third involved moderate caretaker neglect and made the finding unreportable as long as the appellant avoided further mistreatment for 2 years.

Further, we could not verify that the Department's appeal reviewers in

Fiscal Year 2019 considered the factors cited in rule and the appeals manual (e.g., the interests of at-risk adults, the severity of mistreatment, and the likelihood of further mistreatment) when deciding the outcome of an appeal or the conditions of a settlement agreement because there was no documentation of their process. We found the same lack of documentation for the four overturned appeals. Department management told us that staff consider these factors during discussions with the supervisor for some appeals but could not provide any documented evidence.

When appeal reviewers do not document the rationale for appeal outcomes or settlement agreements, management cannot ensure that reviewers' decisions are appropriate and based on consideration of all required factors, or identify areas for additional training. When the Department does not require the appeal process and basis for decisions on appeals to be documented, it loses organizational knowledge of the appeals as time passes and staff change. For example, when we asked the Department to explain the rationale for six instances of severe mistreatment by professionals being made immediately unreportable in a CAPS check, management did not know and had to ask the individual appeal reviewers to recall their reasoning. Further, Department management told us that one staff who reviewed appeals in 2019 is no longer employed with the Department, so management cannot determine the basis for any of the reviewer's decisions.

INCONSISTENT CONSIDERATION OF PERPETRATOR INTENT WHEN DETERMINING WHETHER TO REPORT FINDINGS TO EMPLOYERS. According to Department management, after its appeal reviewers uphold a finding through appeal, they consider the appellant's intent to commit harm when deciding whether the substantiated finding will continue to be reported to employers in a CAPS check. However, Department management told us that counties do not consider intent when determining whether a finding will be reported in a CAPS check, and therefore, all findings that counties substantiate are reported. This inconsistency in how findings are determined reportable in CAPS checks is a fundamental policy disconnect within the Department. Specifically,

the section of the Department that reviews appeals told us that when a finding is upheld in an appeal and they negotiate a settlement with the appellant, if the mistreatment was unintentional the appeal reviewers may make it unreportable in a CAPS check, even though reviewers agree with the county's finding. However, Program staff said that all county findings of substantiated mistreatment should be reportable in a CAPS check, regardless of intent.

Further, as we found, when the reviewers settle with an appellant on an upheld finding, they almost always make the finding unreportable in a CAPS check. We were told that happened in some cases because the mistreatment was unintentional, but we could not determine how the appeal reviewers ascertained intent since the reviewers' analysis for appeals and rationale for making findings unreportable was not documented.

When the Department applies conflicting standards for determining whether substantiated findings of mistreatment against at-risk adults are reported to employers, it can make the CAPS check process inconsistent and unfair to perpetrators. Specifically, the process advantages the substantiated perpetrators with the grounds or means to appeal. Substantiated perpetrators who appeal are likely to have their finding made unreportable through a CAPS check if the Department staff who process the appeal determine that no intent was involved in the case; however, perpetrators who do not have the grounds or means to appeal have their finding reportable in a CAPS check permanently, even when the incident was unintentional.

WHY DID THESE PROBLEMS OCCUR?

GAPS IN GUIDANCE. Many of the problems we identified occurred because the Department has not developed an appeal process for adult protective services cases that fully adheres to the requirements in statute and rule or sufficiently helps ensure that at-risk adults are protected. Instead, for the first 12 months after the appeal process went into place (from July 2018 to July 2019), management directed appeal reviewers to follow the existing appeals manual, which was written for child

welfare cases. In July 2019, the Department revised the manual to include direction and guidance specific to adult protective services appeals. However, we identified the following problems with the revised manual:

- It places heavy emphasis on reviewers seeking settlement with appellants when the Department upholds a county's finding that the appellant mistreated an at-risk adult. Specifically, the manual instructs reviewers to seek settlement agreements during their initial contact with appellants, particularly if the reviewer believes the Administrative Courts would overturn a finding. While the manual states that settlement agreements could be "deemed not appropriate," it lacks guidance on how reviewers should make this determination. Department management told us about one appeal that did not have a settlement agreement and was transferred to the Administrative Courts, but it was unclear to us how it was determined that a settlement was not appropriate because of no documentation and no guidance for making this decision.

  Department management told us that they believe the guidance for appeal reviewers protects at-risk adults, in part because it is designed to reduce the likelihood of an appeal ending in an Administrative Courts hearing. According to the Department, avoiding such a hearing benefits the victim by (1) eliminating hearing costs the victim would have to pay, such as for representation and travel, as well as hearing costs the Department would pay; (2) eliminating the potential to re-traumatize the victim; and (3) more findings becoming unreportable in a CAPS check due to the court's ruling on the appeal. However, our audit work indicates that the policies in the manual can lead to further harm to at-risk adults by making the vast majority of appealed findings unreportable, meaning that employers will not be informed of potential employees or contractors who have mistreated this population.

- It contains little guidance for appeal reviewers when determining the conditions to include in a settlement agreement, including making an upheld finding of mistreatment unreportable in a CAPS check or

setting the timeframes for making a finding unreportable. The Department told us that it has not provided guidance in this area because appeal reviewers need to set the settlement conditions based on the unique facts of each case. If the appeals manual directed appeal reviewers to maintain the reportability of findings in specified circumstances, such as when a professional caretaker is upheld for severe mistreatment and/or has had repeated substantiated findings of mistreatment, the Department could better ensure consistency and equity in the treatment of appellants, while allowing for consideration of each case. The appeals manual also does not establish any parameters for appeal reviewers to follow when determining the timeframe for making a finding unreportable.

One option for making a finding unreportable is requiring the appellant to provide evidence after a period of time that they have been rehabilitated and mistreatment is unlikely to reoccur. For example, in New Jersey, the only way a finding can be made unreportable in a check is by the perpetrator applying to the state to have their names unreportable 5 years after the finding, and by demonstrating with "clear and convincing evidence" that they have been rehabilitated. The evidence that a perpetrator provides may include documentation that they completed training to help ensure that the mistreatment does not reoccur, such as when mistreatment was the result of the perpetrator not following appropriate direct care protocols.

- It provides no settlement conditions to address the mistreatment beyond making an upheld finding unreportable in a CAPS check or downgrading the severity of mistreatment reported through a check, and asking some appellants to stop the mistreatment. The Department has not explored and identified other settlement options that may be viable, nor does it have a standard process to ask appellants for other settlement conditions that they would be willing to agree to before the Department offers to change the upheld finding or make it unreportable in a CAPS check. We reviewed settlement conditions used in appeals sent to Administrative Courts

hearings, which address specific concerns of a case. For example, in one case, the condition was that the appellant agree to never become a caretaker of an at-risk adult. In another case, the conditions were that the appellant pay the at-risk adult's bills on time, because unpaid bills were the premise for the finding, and not have another substantiated finding of mistreatment within 2 years.

- Until recently, it did not require appeal reviewers to document their consideration of specified information, or their rationale for appeal decisions or settlement agreements. From July 1, 2018, when the appeal process began for adult protective services cases, through December 2019, when we spoke to the Department about the lack of documentation, the Department decided 187 appeals. Management told us that it thinks that the appeal reviewers had followed statute and rule, but could not provide evidence of compliance because none of the rationale for appeal decisions were documented and management does not perform supervisory review of each appeal. By rule, all county findings undergo a county supervisory review to ensure that the evidence justifies a finding prior to making it reportable in a CAPS check, yet there is no similar supervisory review at the Department when upheld county findings are made unreportable in a CAPS check. The Department told us that appeal reviewers can discuss difficult appeal cases with the supervisor, but there is not a supervisory review of all appeal decisions or settlement agreements to help ensure the appeal process results in consistent decisions, is compliant with applicable rules and the manual, and adequately protects at-risk adults.

  In January 2020, Department management told us that appeal reviewers began documenting the rationale for their decisions and settlements. We reviewed three upheld appeals that were completed by the Department in February 2020 and that resulted in settlement agreements that made the findings unreportable in a CAPS check. We found that the reviewers for these three appeals did not document that they had considered all required factors or the basis for their decisions. While the reviewers did document various facts

that the counties had found related to the mistreatment incidents, none documented (such as in notes kept by appeal reviewers) why the facts led to the appeal outcome or why the appeal reviewers determined the conditions they included in the settlement agreements. Instead, after listing various facts for the case, the appeal reviewers simply documented the outcome (e.g., upheld, overturned). Department management believes this new form of documentation is sufficient. However, the documentation does not show the rationale for the appeal outcome, which is what the Department expects from counties when they document findings.

- It contains no guidance on using intent in the appeal process. Although Department management told us that appeal reviewers consider the appellants' intent to mistreat when reviewers negotiate settlements, the appeals manual does not mention "intent" and there is no specific guidance or method for how reviewers should determine or consider it. Additionally, the counties are not directed to determine intent and there is no guidance for such a determination when the Program makes findings reportable in a CAPS check. Therefore, there is no written process for determining a perpetrator's intent for the Program or for using it in the appeal process. It is important that the Department reconcile the contradictory practices related to determining intent for reporting findings in CAPS checks.

RECOMMENDATION 2

The Department of Human Services should improve its appeal process for perpetrators substantiated of mistreatment through the Adult Protective Services Program (Program), with a goal of better protecting at-risk adults and making decisions transparent and consistent, by revising written rules and guidance to:

A Instruct appeal reviewers on when it is appropriate and inappropriate to uphold county findings without pursuing settlement agreements, and how to document these decisions.

B Instruct reviewers on how to consider the factors listed in rule and the appeals manual; how to weigh the factors when deciding appeals outcomes; and how to determine the conditions to include in an agreement, including the circumstances in which it is warranted to make an upheld finding unreportable in a check of the Colorado Adult Protective Services system (CAPS check) and the timeframes, if any, for making a finding unreportable.

C Explore and identify settlement condition options for upheld appeals other than making mistreatment unreportable in a CAPS check, and implement options that are most feasible. This could include a process to identify conditions based on the unique circumstances of each appeal when negotiating settlements with the appellant.

D Require appeal reviewers to document the rationale for their appeal decisions and the conditions they include in settlement agreements, including making a finding unreportable in a CAPS check.

E Enhance supervision to include supervisory review of documentation of appeal decisions and outcomes prior to finalizing the outcome with appellants to help ensure the appeal process is consistent across reviewers, compliant, and upholds statutory intent to protect at-risk adults.

F Reconsider whether intent will be considered by Program staff and appeal reviewers when they are making a substantiated or upheld finding reportable in CAPS checks.

G If it is determined that intent will be considered when making substantiated or upheld findings reportable in CAPS checks, implement a standard method and guidance for determining intent and reporting the findings based on that determination.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department agrees to provide additional instruction to appeal reviewers on when it is appropriate and inappropriate to uphold county findings without pursuing settlement agreements, and how to document these decisions. Guidance regarding appropriateness of entering into settlement negotiations is currently provided verbally during bi-weekly individual staff supervision, weekly team meetings for staff members in the Department's Child and Adult Mistreatment Dispute Review Section (CAMDRS), and individual meetings as requested by these staff members. The Department will enhance the appeals manual to include better definitional clarity of what each of the factors is intended to consider, as well as examples of how they may inform decisions regarding appropriateness of considering entering into settlement agreements. The appeals manual will also be updated to include direction on how to document the decision regarding appropriateness of settlement.

B AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department agrees to provide additional instruction to reviewers on how to consider the factors listed in rule and the appeals manual; how to weigh the factors when deciding appeals outcomes; and how to determine the conditions to include in an

agreement, including the circumstances in which it is warranted to make an upheld finding unreportable in a check of the Colorado Adult Protective Services system (CAPS check) and the timeframes, if any, for making a finding unreportable. Guidance regarding how to consider the factors listed in rule, when to expunge (i.e., making a finding unreportable at a certain point in time) a finding and any conditions to include in settlements is currently provided verbally during bi-weekly individual staff supervision, weekly CAMDRS team meetings, and individual staff meetings as requested by staff members. The Department will enhance the appeals manual to include better definitional clarity of what each of the factors is intended to consider, as well as examples of how they may inform decisions regarding expungement of records for purposes of a background check and any conditions to include in the settlement terms.

C AGREE. IMPLEMENTATION DATE: MARCH 2021.

The Department agrees to explore and identify settlement conditions for upheld appeals when making mistreatment unreportable in a CAPS check, and implement options that are most feasible. The Department currently includes conditions requiring no future founded allegations of mistreatment of an at-risk adult when terms are added to some settlement agreements. The Department agrees to consider additional options for conditions that may be appropriate to include in settlement agreements and implement those that are most feasible by including guidance on the options in the appeals manual.

D AGREE. IMPLEMENTATION DATE: JULY 2020.

The Department agrees to require appeal reviewers to document the underlying factors serving as the basis for appeal decisions and the conditions they include in settlement agreements, including making a finding unreportable in a CAPS check. Each appeal requires consideration of a set of factors unique to the circumstances of the incident of mistreatment, as well as factors unique to each appellant.

In early 2019, the Department initiated internal discussions focused on identifying a process for documenting specific factors relevant to each appeal and the decision they informed. The Department implemented a process in January 2020, and has continued to enhance the process since that time. The process requires staff to document the evidence that supports the decision to uphold or overturn the finding, based on the definition for the specific alleged mistreatment category(ies). Additionally, for upheld findings, staff are required to document the unique factors and circumstances that informed the decision regarding appropriateness of settlement, as well as any identified settlement terms. The Department will revise the appeals manual to include this expectation.

E AGREE. IMPLEMENTATION DATE: JULY 2020.

The Department agrees to enhance supervision to include supervisory review of documentation of appeal decisions and outcomes prior to finalizing the outcome with appellants to help ensure the appeal process is consistent across reviewers, compliant, and upholds statutory intent to protect at-risk adults. Individual, supervisory, case consultation occurs on more complex appeals during bi-weekly meetings between the supervisor and the appeal reviewers. This process will be enhanced to include targeted reviews, discussions, and approvals of the summary documentation of the relevant factors considered specific to the decision(s) for appeals discussed during individual supervision.

F DISAGREE.

The Department disagrees with the need to reconsider how intent will or will not be considered in the processes that lead to the determination for making a finding reportable during a CAPS check. There are two points at which a decision is made that results in whether or not a substantiated finding is made reportable in a CAPS check.

1) When the county makes a finding on an allegation as the result of an investigation.

2) After the appeals process is complete.

The Department disagrees that intent should be considered in the same way in each of these two processes.

The county's role is to conduct an investigation using the resulting facts and evidence to determine whether mistreatment occurred, as defined in statute. It is not the county's role to determine the perpetrator's intent to mistreat. As a result, intent is not considered when making a finding in an investigation. Likewise, the Department does not consider intent when determining whether or not to uphold the county's finding as part of the appeal process.

However, when the Department upholds a finding as part of the appeals process, settlement negotiations may begin. Every perpetrator has an opportunity to appeal a finding. Intent, in conjunction with other factors, may be, but is not always, considered during this process. Rule authorizes the Department to enter into settlement negotiations and take into consideration factors which may include intent.

AUDITOR'S ADDENDUM

The audit found that the Department has inconsistent internal policies and practices for making a substantiated finding of mistreatment reportable to employers in a CAPS check. Department appeal reviewers consider a perpetrator's intent when making a substantiated and upheld finding reportable in a CAPS check, but Program staff do not consider intent when making a finding reportable. This disconnect in how the Department considers intent has resulted in appeal reviewers making most upheld findings unreportable, even though the reviewers agreed with the counties' decisions, and Program staff not considering or determining a perpetrator's intent when it may be meaningful for an employer in a CAPS check.

G PARTIALLY AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department partially agrees with this recommendation. As referenced in the response to RECOMMENDATION 2F, the Department does not consider intent when the county makes a finding on an allegation as the result of an investigation or when making a determination to uphold or overturn findings of mistreatment of an at-risk adult.

When determining the appropriateness of entering into settlement negotiations, as well as potential terms in the settlement agreement, intent is a factor that may be considered. As a result, the Department agrees to document and provide guidance on a standard approach for determining intent as part of the appeals settlement process and reporting the findings based on that determination. The Department will revise the appeals manual to document and ensure clarity of the standard of intent and when it may be considered as part of the appeal process.

AUDITOR'S ADDENDUM

The audit found that the Department is inconsistent in its consideration of a perpetrator's intent. The Department's response indicates that it will not resolve the inconsistency, which means that one section of the Department will continue to consider intent when determining whether to make substantiated findings of mistreatment reportable in CAPS checks, but another section of the Department will not consider intent when determining whether the same findings are reportable.

APPEAL TIMELINESS AND NOTIFICATIONS

As part of establishing employer CAPS checks and an appeal process for perpetrators, House Bill 17-1284 required the Department to establish a process to resolve appeals in a timely manner, including notifying perpetrators about their right to an appeal [Sections 26-3.1-108(2), C.R.S., and 30.920(I), 12 CCR 2518-1]. Counties use CAPS to generate a letter to notify each perpetrator of their appeal rights. Perpetrators have 90 days from the date of the county's notice to submit an appeal to the Department's Child and Adult Mistreatment Dispute Review Section. The Department mails each appellant an acknowledgement of the appeal and provides more information about the appeal process, such as that the Department is willing to negotiate settlement agreements before an appeal is forwarded to Administrative Courts. As part of the appeal process, appellants may request information about the case, which the Department provides after redacting information that it considers confidential. In Fiscal Year 2019, counties sent 1,240 notifications to perpetrators and the Department received 250 appeals.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of the audit work was to evaluate processes for ensuring that counties notify perpetrators of their right to appeal and the Department notifies appellants of their rights once they have submitted an appeal, as well as to evaluate whether appeals are timely, in accordance with statute and rule. We analyzed CAPS data on (1) the timeliness of county notifications for all 1,240 letters they sent in Fiscal Year 2019, (2) the Department's notifications to appellants for all 469 appeals from July 2018 through December 2019, and (3) the timeliness of the 469 appeals. In addition, for our sample of 16 of the 87 appeals

resolved in Fiscal Year 2019, we analyzed the Department's CAPS data and hardcopy files, including the notification letters that the counties sent to perpetrators and that the Department sent to appellants. We reviewed redacted case information sent to the two appellants in our sample who requested this information. We interviewed staff and supervisors in 10 counties and Department staff and management. We also reviewed redaction guidance that the Department received from the Colorado Office of the Attorney General in 2011 and that the U.S. Department of Justice has published.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

- **The Department must resolve appeals in a timely manner.** Rules require appeals to be resolved within 120 calendar days of the Department's receipt of the appeal and allow that timeframe to be extended upon "agreement of both the appellant and the Department if it is likely that the additional time will result in a fully executed settlement agreement or resolution of the appeal" [Section 30.920(L), 12 CCR 2518-1], or if the appellant has a criminal trial [Section 30.920(G), 12 CCR 2518-1]. According to rules, "As soon as it is evident within the 120 days that the appellant and State Department will not resolve the issue(s) on appeal, the State Department shall forward the [appeal] to the Office of Administrative Courts" [Section 30.920(M), 12 CCR 2518-1].

- **County notifications must be timely.** Counties must notify each perpetrator of the finding of mistreatment that was substantiated and the perpetrator's right to appeal the decision within 10 calendar days of the date of the finding [Section 30.910(A), 12 CCR 2518-1].

- **Appellants have the right to request certain redacted information about the finding.** Rules state that appellants are allowed to "have access to the case record relied upon by the county department to make the finding in order to proceed with the appeal"

[Section 30.920(I)(1),12 CCR 2518-1]. However, the information that may be given to an appellant is limited. Rules state that when providing information to the appellant "the State Department shall redact identifying information contained in the case record and documents to ensure compliance with all state and federal confidentiality laws and rules regarding adult mistreatment records or other protected information, including but not limited to: reporting party name(s)…and information pertaining to other parties in the case that the appellant does not have a legal right to access" [Section 30.920(I)(2), 12 CCR 2518-1]. According to the Department, this rule is based on language in the rules for child welfare appeals [Section 7.111(J), 12 CCR 2509-2]. When providing information to appellants, staff also rely on specific guidance that the Department received from the Attorney General in 2011 for child welfare case appeals. This guidance gives instructions on what type of information should be redacted from certain documents such as: family information from daycare records, confidential minutes from court records, and the names of abused children which should be redacted down to their initials in case information from the Department's database.

WHAT PROBLEMS DID THE AUDIT IDENTIFY AND WHY DO THE PROBLEMS MATTER?

ALMOST ONE-HALF OF APPEALS WERE NOT RESOLVED IN A TIMELY MANNER. The Department did not resolve 205 of the 469 appeals filed between July 2018 and December 2019 (44 percent) within the required 120 calendar days. None of these untimely appeals had been forwarded to the Administrative Courts or delayed due to ongoing criminal or court proceedings. On average, the Department took 230 calendar days to complete these appeals, or 110 days past the 120-day deadline. The appeals that exceeded the deadline were between 1 and 350 days late, as of December 31, 2019. Our sample of 16 resolved appeals contained six (38 percent) that were not resolved within 120 days. We attempted

to determine what factors contributed to delays in resolving appeals by reviewing the case files for these six. Specifically, we found:

- **No written explanation to indicate why some appeals were untimely.** For four of the appeals in our sample that were late, the Department did not document its rationale for exceeding the required 120-day timeframe or for not forwarding the appeals to Administrative Courts for hearing once they exceeded the timeframe, as required by rule. The appellants in two of these cases were professionals who served at-risk adults. The Department eventually executed settlement agreements that made each finding unreportable in a CAPS check after about 2 years if the appellants did not mistreat an adult during the period.

- **Reasons for extensions not documented.** For the other two appeals in our sample that were not completed within 120 days, the files contained handwritten notes that the appellants had requested an extension. The first appeal took 238 days to resolve and had no other notes to indicate the Department's reason for the extension. The second appeal took 404 days to resolve and the note said that the appellant requested a delay until the conclusion of their criminal trial. There was no information about the trial in the file or CAPS to indicate that a trial was taking place. The Department eventually executed settlement agreements that made both findings unreportable in a CAPS check after 1 year for the first appeal and 5 years for the second appeal, if the appellants did not mistreat an adult during that time.

When appeals are not resolved in a timely manner, it delays due process for the appellant and extends the amount of time that the finding is reportable in a CAPS check during the appeal. A finding of mistreatment is reportable in a CAPS check beginning on the date the county substantiates the finding; it remains reportable throughout the appeal process. If the appellant did not commit the mistreatment, then extending the time that the finding is reportable in a CAPS check could unfairly affect their employment if an employer chooses to not hire or no longer employ them based on the CAPS check information. Further, if the

Department ensures that all settlement agreements for appeals had conditions and makes the conditions more robust to help prevent further mistreatment, as discussed in the section "Outcomes of Appeals for Perpetrators," then timely appeal conclusions will be even more important so that the conditions placed on appellants are not delayed. For example, between February 2019 and February 2020, five appellants had appeals pending for over 120 days, and during this time, counties substantiated that the appellants committed additional mistreatment subsequent to the original incidents. Six more substantiated findings were made against one of these appellants while the first appeal was ongoing and the appellant submitted appeals for each of the subsequent substantiations, but none of the appeals for this individual had been resolved as of the end of our fieldwork. Had the appeals been timely and included conditions to address the mistreatment, it is possible that they could have helped prevent further mistreatment.

A SMALL NUMBER OF COUNTY NOTIFICATIONS WERE NOT TIMELY. For 52 of the 1,240 letters notifying a perpetrator of a substantiated finding of mistreatment and their right to appeal in Fiscal Year 2019 (4 percent), the letters were between 1 and 432 days past the 10-calendar day requirement in rule. Of these 52 late letters, 25 were sent less than 1 week late, 12 were sent between 1 week and 1 month late, and 15 were sent more than 1 month after the 10-calendar day requirement. When these counties do not notify substantiated perpetrators of findings and their right to appeal in a timely manner, it creates an inequitable process because some are not aware of the findings about them that will appear in a CAPS check or that they can appeal the findings.

APPELLANTS ARE NOT INFORMED OF SOME RIGHTS. We found that the letter the Department sends appellants about the appeal process lacks key information required by rules. First, the letter does not notify appellants that they can request an extension beyond 120 days. Second, the letter does not inform appellants of their right to request the case information that the county used to determine the finding. Only two appellants in the 16 appeals we sampled requested case information, which may indicate that not all appellants are aware of this right.

THE DEPARTMENT IS INCONSISTENT IN REDACTING INFORMATION PROVIDED TO APPELLANTS. For the two appeals we reviewed where the appellant requested case information, we found that the Department was inconsistent when redacting and providing information to the appellants. For one appeal, the Department provided the appellant with a 10-page summary that contained sensitive information that may have unduly infringed upon the privacy of the at-risk adult and others involved with the case. Specifically, the summary included:

- The first name of the adult victim,
- The names of the adult's financial institutions, even though the appellant was found to have financially exploited the adult,
- The first names of the adult's guardians,
- The first name of a person who, according to the case record in CAPS, had reported the mistreatment,
- The full names of county staff involved with the case, and
- The titles and last names of law enforcement officers involved with the case.

In contrast, for the second appeal, the appellant received a one-page summary of the county's finding that redacted all identifiable and protected information, and only reported the initials of the at-risk adult and appellant.

Due process involves the State and the appellant sharing evidence with one another. The Department's current appeal process impinges on appellants' due process by not fully informing appellants of their rights and not providing consistent types and amounts of information to different appellants. When the Department provides appellants with confidential, sensitive information about a case, which should be redacted, it infringes on the rights of the at-risk victims and others involved in adult protective services cases. Not redacting properly can potentially put the victim at further harm and risk the safety of the

adults' support networks. For example, including in documents the names of the banks used by the victim could be useful for an appellant who has been found to have financially exploited the adult, and including the names of the people that counties interviewed and of caseworkers could expose these people to harassment from appellants.

WHY DID THESE PROBLEMS OCCUR?

LACK OF CONTROLS OVER TIMELY APPEAL PROCESSING. First, the Department does not require its appeal reviewers to document why an appeal exceeded the 120-day timeframe or the rationale for extensions. Furthermore, according to Department management, its appeals manual required appeal reviewers to document their contacts with appellants, but reviewers have not been following the manual by documenting, and the manual contains no guidance on how reviewers are to document that (1) an appellant requested an extension, (2) both parties agreed to an extension, or (3) the extension was needed to resolve the appeal.

Second, the Department has no written guidance for staff to promote timely processing of appeals. For example, the Department has not set written expectations for appeal reviewers with respect to completing each phase of their work to ensure that appeals are completed on time. There is also no written process or guidance for appeal reviewers to use to determine when it is "evident" that a settlement will not be reached, and that the case should therefore be forwarded to the Administrative Courts. Written guidance might include general timeframes for how quickly reviewers should contact all relevant parties to request information, how long reviewers should take to review information when the parties provide it, how quickly reviewers should determine the appeal outcome to allow sufficient time to negotiate a settlement agreement, and how to determine when a settlement cannot be reached, which must occur prior to the end of the 120-day timeline in rule.

Furthermore, the Department did not have a supervisory review process to monitor appeal timeliness or the time needed for an appeal prior to January 2020. For example, appeal reviewers were not required to

record when key steps in the appeal process occurred so that the information could be used by reviewers or supervisors to identify the reasons for delays and address them. If the Department had required such recording, it could have tracked how long reviewers took to complete various work activities and established processes to address appeals that did not progress in a timely manner. As discussed in the "Outcomes of Appeals for Perpetrators" section, the Department also does not have a supervisory process to review all appeal decisions to ensure compliance with rules. In January 2020, the Department developed a new database to begin tracking due dates for some steps of the appeal process and the dates that the steps are completed. According to the Department, a supervisor began reviewing these data in March 2020 to look for approaching due dates, missed deadlines, and certain other issues, such as missing copies of settlement agreements, and then meets with appeal reviewers about the issues. Because this new process began at the end of the audit, we did not determine whether it has improved the timeliness of appeals.

More monitoring and training needed to ensure that counties follow the notification timeline. Department staff told us that they remind counties to mail notification letters to perpetrators within 10 days of a finding. The Department also relies on reports generated by CAPS and emails to inform counties to send notification letters on time, but the counties we identified that sent untimely notification letters did not appear to use this information to ensure that letters were sent on a timely basis. Department staff do not proactively reach out to counties when letters are overdue to inquire why they are late. These problems indicate that the noncompliant counties with untimely notifications need additional guidance and/or training on using the information from CAPS to ensure timely notifications.

Department management narrowly interprets rules on notification. Department management told us that it does not include language in the letters sent to appellants to inform them that they may request (1) an extension in their appeal and (2) case record information because rules do not explicitly require such notification. However, this

appears to be a narrow reading of the rules, which include the following statement: "After the appellant requests an appeal, the State Department shall inform the appellant of the *details regarding the appeal process*." [Emphasis added] [Section 30.920(I), 12 CCR 2518-1]. A reasonable reading of this rule is that the Department should inform appellants of all pertinent details of the process, including the right to request an extension and to obtain case record information.

Unclear guidance on what type of information to send to appellants. During Fiscal Year 2019, Department staff did not have clear instructions on what type of case record information to send to appellants (e.g., a summary of just the county's decision for substantiation or the entire case summary) or on what and how to redact. From July 2018 to July 2019, reviewers of adult protective services appeals followed the guidance that was established in 2011 for child welfare appeals, which only addressed redacting children's records. In July 2019, the Department updated its appeals manual to include instructions to reviewers of adult protective services appeals about sending appellants the case summary from CAPS. However, the manual provides vague instructions on redaction, saying that case files must be redacted "in order to protect confidential information," without any direction on what specific types of information must be redacted and to what extent. The Department told us that it requested advice from the Office of the Attorney General on redacting case information properly for adult protective services appeals, but as of April 2020, has not received finalized advice. Furthermore, the Department does not have a supervisory review process to ensure that redactions are appropriate. Supervisory review before case record information is sent to appellants could help the Department ensure that redactions are consistent.

The U.S. Department of Justice issued guidance on redactions and disclosures under the Freedom of Information Act, which could help guide the Department in determining what case information to release to appellants, at least until the Department receives advice from the Attorney General. The Department of Justice guidance states that

information should be redacted if it results in an unnecessary invasion of personal privacy; privacy protection must be afforded to people who provide information to investigative bodies; care should be taken to protect the identities of people involved with a case, including the person who reports mistreatment; and sometimes redacting a person's name is not enough protection if their identify can be revealed through context of the information provided. The guidance also emphasizes the importance of redacting individuals' financial information to limit their exposure to unwanted attempts by others to access their money.

RECOMMENDATION 3

The Department of Human Services (Department) should ensure that the appeal and notification processes for the Adult Protective Services Program follow statute and rules by:

A Requiring Department appeal reviewers to document why an appeal exceeds the required 120-day timeframe. This should include implementing written guidance for documenting requests for extensions from appellants and agreed-upon extensions.

B Implementing written guidance to promote timely processing of appeals, including guidance for evaluating when a settlement agreement cannot be reached and a case should be forwarded to Administrative Courts.

C Implementing a process to verify that supervisory reviews work as intended to identify approaching due dates and missed deadlines for appeals, address the issues identified, and help ensure timely appeal resolutions.

D Implementing a follow-up process and additional guidance and/or training for the counties with untimely notifications of findings and appeal rights, to help ensure that they send perpetrators notification letters within the required 10 days.

E Revising the Department's appeal notification letter so that it informs appellants of their right to request an extension of their appeal and to request case information.

F Implementing written instructions for appeal reviewers that provide specific direction on the types of information that must be redacted from case information, and implementing a supervisory review of redactions prior to sending information to appellants.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JULY 2020.

The Department agrees to require appeal reviewers to document why an appeal exceeds the required 120-day timeframe, including implementing written guidance for documenting requests for extensions from appellants and agreed upon extensions. The Department implemented the Adult Appeals Management System database in January 2020. The database includes a check box used to indicate agreement between the appellant and appeal staff to extend discussions beyond the 120 day timeframe. The Department will update the appeals manual to include the expectation that the reason for the extension be documented in the comments field within the database.

B AGREE. IMPLEMENTATION DATE: AUGUST 2020.

The Department agrees to implement written guidance to promote timely processing of appeals, including guidance for evaluating when a settlement agreement cannot be reached and an appeal should be forwarded to the Administrative Courts. The Department implemented the Adult Appeals Management System database in January 2020. As part of the implementation, expectations were created for timeliness of completion of certain aspects of the appeal process. The database was designed to include data fields that capture when the steps are completed. Based on the expectations, the database also includes report functionality that helps identify steps coming due, or are overdue, for each individual appeal. The Department will revise the appeals manual to include written guidance regarding the timeframe expectations. The manual will also be revised to include guidance on determining when it is evident that a settlement agreement cannot be reached.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department agrees to implement a process to verify that supervisory reviews work as intended to identify approaching due dates and missed deadlines for appeals, address the issues identified, and help ensure timely appeal resolutions. The Department created the Adult Appeals Management System in January 2020. The database includes report functionality allowing the supervisor to run a report displaying the status of each appeal. The report flags appeals that have steps with associated timelines coming due, or are overdue. This allows the supervisor and staff to quickly identify and prioritize the timely completion of these steps. The Department began using the report in February 2020. Since then, enhancements were identified and made to the report functionality. The report is currently run a minimum of once per week and reviewed to ensure progress across appeals. Additionally, over a period of six months, Department management will implement a monthly review of the report to monitor timely completion of appeals and identify potential process improvements.

D AGREE. IMPLEMENTATION DATE: AUGUST 2020.

The Department agrees to implement a follow-up process and additional guidance and/or training for the counties with untimely notifications of findings and appeal rights to help ensure that notifications are sent timely to substantiated perpetrators. Specifically, in addition to the three mechanisms the State APS Program used to monitor perpetrator notification timeliness that existed in State Fiscal Year 2018-19, the Department has also implemented a fourth strategy in February 2020 to help ensure county departments are sending these notifications timely. By August 2020, the Department will develop and launch a new process to follow up and provide individual training for those county departments that are routinely sending these letters after the ten (10) days allowed by rule.

E AGREE. IMPLEMENTATION DATE: AUGUST 2020.

The Department agrees to revise the appeal notification letter to include information regarding the right to request an extension of an appeal and to request case information related to the investigation under appeal. This language update will require changes to the CAPS system and will be implemented by August 2020.

F AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department agrees to implement written guidance for appeal reviewers that provides specific direction on the types of information that must be redacted from case information prior to sharing the information with appellants upon their request. The Department has been working with the Office of the Attorney General to identify federal and State confidentiality statutes that may relate to information contained in the Adult Protective Services case. This guidance will be incorporated into the appeals manual. In order to ensure consistent understanding and application of the guidance, a targeted sample of draft redactions will be reviewed for three months after implementation of the guidance.

SCREENING OF REPORTS OF MISTREATMENT AND SELF-NEGLECT

Counties receive reports of alleged mistreatment and self-neglect of at-risk adults and enter them into CAPS. Some reports include detailed information, such as when someone provides documentation of financial exploitation of an at-risk adult, while other reports have limited information, such as when someone anonymously phones the county to report suspected self-neglect of an adult who appears to be at-risk. Counties review the allegations and use a series of screening intake questions in CAPS to attempt to obtain as much information as possible from the reporting party about the adult and the allegations of mistreatment and/or self-neglect. The county uses this information to determine whether the report should be screened in, meaning that they will begin an investigation to determine if the allegations can be substantiated; otherwise, the county will screen out the report and take no further action. Counties sometimes receive multiple reports about the same adult or the same alleged perpetrator.

EXHIBIT 2.5 shows that the number of reports of suspected mistreatment or self-neglect of an adult that were submitted to a county office increased from Fiscal Year 2017 to Fiscal Year 2019. During these 3 fiscal years, counties screened in an average of about 34 percent of the reports and screened out about 66 percent.

EXHIBIT 2.5. ADULT PROTECTIVE SERVICES REPORT SCREENING DECISIONS BY COUNTIES FISCAL YEARS 2017 THROUGH 2019

SCREENING DECISION	2017	2018	2019
Screened In	7,374	7,601	7,735
Screened Out	12,955	14,982	17,266
TOTAL	20,329	22,583	25,001

SOURCE: Office of the State Auditor analysis of data from CAPS.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of our audit work was to assess the county processes for screening reports of suspected mistreatment and self-neglect. We analyzed aggregate data for all 25,001 reports that the Program recorded in CAPS during Fiscal Year 2019 to understand the timeliness of screening decisions and to identify: (1) the adults who had the most reports about them during the year and (2) the alleged perpetrators who had the most reports about them alleging mistreatment during the year. From our analysis of all 25,001 reports submitted to counties in Fiscal Year 2019, we selected two groups of reports to review:

- 145 reports for the six adults and six alleged perpetrators with the most reports during that year. Eighty-seven of these reports were screened out and 58 were screened in.
- A random sample of 66 reports, which included 21 that the counties screened out and 45 that they screened in.

In total, we reviewed case notes and documentation for 211 reports of suspected mistreatment or self-neglect to evaluate the counties' compliance with the requirements described in the next section. We also interviewed Program staff as well as staff and supervisors at 10 counties to understand the screening process.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Statute and rule in place for the period of our review outline the process that counties must follow when determining whether to screen in or screen out a report involving allegations of mistreatment or self-neglect.

First, the county must:

- Determine whether it appears to involve an at-risk adult, which is an individual 18 years 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 [Sections 26-3.1-101(1.5), C.R.S., and 30.100, 12 CCR 2518-1]. Rules further state that if a report does not contain information that indicates that the adult is at-risk, the report should be screened out [Section 30.420(F), 12 CCR 2518-1].

Second, if the county determines that a report appears to involve an at-risk adult, then the county must determine if the report involves either of the following:

- Mistreatment, which is abuse; caretaker neglect; exploitation; an act or omission that threatens the health, safety, or welfare of an at-risk adult; or an act or omission that exposes an at-risk adult to a situation or condition that poses an imminent risk of bodily injury to the adult [Sections 26-3.1-101(7), C.R.S., and 30.100, 12 CCR 2518-1].

- Self-neglect, which is 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 essential human needs [Sections 26-3.1-101(10), C.R.S., and 30.100, 12 CCR 2518-1].

According to rule, reports involving an at-risk adult and mistreatment and/or self-neglect shall be screened in and investigated [Section 30.420(G), 12 CCR 2518-1]. In addition, rules state that when the county has a current open case that it is investigating and it receives a new allegation about the same at-risk adult, the new report shall be screened out and the new allegation shall be added to and investigated in the current open case [Section 30.430, 12 CCR 2518-1]. According to Program staff, when a county receives multiple reports about an alleged perpetrator who is suspected of mistreating multiple adults in a single instance, the county is required to create a report in CAPS for each adult who was allegedly mistreated and evaluate each report individually.

Third, statute requires counties to "immediately make a thorough

evaluation of the reported level of risk" of each report and "[t]he immediate concern of the evaluation is the protection of the at-risk adult. The evaluation, at a minimum, must include a determination of a response timeframe and whether an investigation of the allegations is required" [Section 26-3.1-103, C.R.S.]. Rules require counties to enter reports into CAPS, including the date the county received the report (referred to as the report date), within 1 business day of receiving the report, and must make the screening decision within a maximum of 3 business days after receiving the report [Sections 30.410(C) and 30.420(F), 12 CCR 2518-1].

WHAT PROBLEMS DID THE AUDIT IDENTIFY AND WHY DO THEY MATTER?

We did not identify problems with the county processes for any of the 103 screened in reports that we reviewed, but we did find problems with 19 of the 108 reports we reviewed that the counties screened out (18 percent). Two of these 19 reports were from our random sample, 17 were from our review of reports for the adults and alleged perpetrators with the most reports that year, and the screening problems occurred in four counties. We also found problems with some report dates in CAPS, making it difficult to determine the timeliness of screening decisions in 20 counties, as follows:

REPORTS INCORRECTLY SCREENED OUT. Counties screened out 12 reports incorrectly because each included at-risk adults who were allegedly mistreated or self-neglected, as follows:

- **SIX REPORTS OF ONE ALLEGED PERPETRATOR MISTREATING MULTIPLE AT-RISK ADULTS.** In November 2018, an assisted living facility reported that a nurse who was responsible for the medical supervision of 15 residents left her shift without approval, which met the definition of mistreatment because the nurse did not provide adequate supervision. The county improperly screened-out these six reports for at-risk adults, documenting in CAPS that "actual mistreatment could not be identified."

- **FIVE REPORTS OF MISTREATED AT-RISK ADULTS.** In November and December 2018, a county received two reports alleging physical abuse of the same at-risk adult by other residents at an assisted living facility. The county screened out the two reports because it was investigating another open case involving allegations of sexual abuse of the adult. However, the county did not update the open case in CAPS to document the new allegations or investigate them, as required by rules.

  In another report, a social worker reported that an adult with mental health and medical diagnoses was being neglected by a caregiver in March 2019 and the adult could not independently manage their medical conditions. The report said that a doctor recommended 24-hour care for the adult, which the caregiver refused to provide. According to notes in CAPS, the county concluded that the adult was not at-risk because the report had no information about the adult's "cognition and activities of daily living," but this is not part of the definition of an at-risk adult, and the county had enough information in the report to determine that the adult was at-risk and assess whether there was mistreatment.

  Two reports that a county received in October 2018 and January 2019 alleged that the same at-risk adult was punched and slapped by other residents at a facility, which caused the adult to cry. The county screened out both reports, documented in CAPS that it could not determine if the adult had felt pain, and wrote "no mistreatment." According to statute [Section 26-3.1-101(1)(a), C.R.S.], mistreatment in the form of physical abuse includes the non-accidental infliction of pain or injury, and both reports noted that the adult cried, which is a reasonable indicator that the adult felt pain from the alleged abuse.

- **ONE REPORT OF SELF-NEGLECTING AT-RISK ADULT.** An adult's friend reported in April 2019 that the adult was disoriented, agitated, could not remember their name or the date, refused to see a doctor, and that the behavior developed suddenly and was uncharacteristic. Notes in CAPS said that the county screened out the report because

there was "no mistreatment," but the county failed to recognize that the adult's behavior met the definition of a self-neglecting adult.

Program staff reviewed all 12 of the reports above, at our request, and agreed that the counties should have screened in and investigated them.

INCORRECT SCREEN OUT REASON ENTERED INTO CAPS. For five reports related to the November 2018 mistreatment by the nurse who left the shift at the assisted living facility, the county recorded the wrong screen out reason in CAPS, citing "no mistreatment" when the reason was that the five adults were not at-risk. Program staff agreed that the county did not record the correct screen out reason in CAPS for these five reports.

REPORTS SCREENED OUT FOR REASONS NOT IN LINE WITH STATUTORY INTENT. Counties screened out two reports for the following reasons that do not appear to align with the statutory purpose of the Program:

- **ALLEGED REFUSAL OF PAST SERVICES.** In August 2018, a home health care worker reported concerns about a self-neglecting adult who was not taking medications correctly and experiencing hallucinations. Notes in CAPS said that the county screened out the report because the adult "has history of refusing services or being non-compliant with services." However, CAPS showed that the adult had consented to receive services in December 2017 for self-neglect, and that there was no indication in statute that a report can be screened out based on an adult's refusal of services in the past. Program management said that the county should have screened in this particular report for investigation because the case involved alleged self-neglect of the adult. Management also said that it believes that screening out a report because an at-risk adult previously refused services is a legitimate reason if the report concerns self-neglect that is not substantively different from prior allegations, and the adult is competent, has refused past services, and was assessed for services in the previous 6 months.

- **REPEATED ALLEGATIONS.** In March 2019, an adult who lived in a facility reported being physically and sexually assaulted by facility

staff. That county screened out the report and wrote in CAPS "screen out; no mistreatment. [Adult] has history of making similar allegations without merit." The county did not appear to determine whether the adult was at-risk and appeared to use the adult's history of making reports as a reason to screen out the report. The county appeared to rely on notes in CAPS from previous reports to screen out the March 2019 report because in September 2018 this adult made 12 reports of physical and sexual abuse by staff in a different facility and county. That county had screened out the 12 reports because the adult "does not meet the criteria as an at-risk adult." Even if the prior reports from 2018 did not have merit, the new reports could have, since they were about a different facility and the adult's at-risk status could have changed. Statute does not indicate that counties can screen out reports of mistreatment because an adult has reported prior allegations. Program management said that the county should have screened out the March 2019 report because the adult was not at-risk and that it believes screening out a report from an at-risk adult who has made past allegations is not a legitimate reason.

When counties improperly screen out reports, they fail to protect at-risk adults who could continue to be mistreated or self-neglecting without any services that they may need to improve their safety and health. For example, in the screened out report in March 2019 involving an at-risk adult being neglected by a caregiver, the county received two more reports in April and June 2019 involving alleged financial exploitation and self-neglect of the adult. The county screened in the June 2019 report, which resulted in the county coordinating in-home services for the adult and the adult's daughter becoming power of attorney. Had the county assessed the adult's circumstances and screened in the report for this adult in March 2019, the adult could have received the needed services in a timelier manner.

Furthermore, when counties improperly screen out reports, the individuals who allegedly mistreat at-risk adults are not investigated or held accountable for their actions. For example, the nurse who left her shift without approval was not investigated for mistreatment. If she had

been investigated and the alleged mistreatment had been substantiated, the finding would be recorded in CAPS. Although, as discussed in the "CAPS Background Checks" and "Policy Considerations for CAPS Checks" sections, the Department and the county would not have informed the assisted living facility where the nurse worked at the time of the finding, and therefore, the employer may not have taken any action to address the nurse's behavior. Rather, the finding could be reported to a subsequent employer considering the nurse for a position working with at-risk adults.

INACCURATE REPORT DATES IN CAPS. We found that counties generally screened reports of mistreatment and self-neglect within the required timeframes in Fiscal Year 2019. However, we reviewed a standard report in CAPS showing the history of changes to the report date field, and identified 99 reports related to 20 counties for which we could not determine the timeliness of screening decisions because county staff changed the date that the reports were received to a later date, without any notes in CAPS to justify the changes. Counties changed the report dates to dates that ranged from 2 to 389 days after the county had originally received the reports, including 68 where the dates in CAPS were changed to a date that was 1 week later or more. For example, one county changed the date it received the report from September 7, 2018 to May 7, 2019, and another county changed a report date from May 26 to June 18, 2019. Neither county included an explanation in CAPS regarding the reason for the date change. The date that the county receives the report is important because it is the starting point for deadlines required in rules to complete the screening process, as well as the investigative process for the reports that are screened in. When counties change the report date in CAPS to make it later, it gives the appearance that the counties were timely with screening processes, and in some cases the investigations, when they may not have been. Program staff were not able to determine the reason for these date changes but thought they were made to fix typographical errors that occurred at the start of a new year. However, the only instance we could identify of a date changing around a new year was a change from February 12, 2018 to February 13, 2019.

WHY DID THESE PROBLEMS OCCUR?

Additional training needed for counties. Although Program staff have issued guidance via tip sheets to help counties with making decisions on screening reports, some counties continue to screen out reports for reasons that are incorrect or not allowable. According to Program staff, the problems we found are likely due to county staff misinterpreting the definitions of "at-risk," "mistreatment," and "self-neglect." In addition, the Department has not provided counties with training on screening since May 2019, except for training that counties receive for new caseworkers. Program staff provide counties quarterly optional training on various topics, but the training since May 2019 has not covered screening decisions. Further, some county staff told us that it can be difficult to obtain clear, complete answers to the screening intake questions. For example, when a friend or neighbor reports suspected mistreatment of an at-risk adult, they may not be able to answer questions about the adult's overall health condition, capacity, or financial situation. The problems we found in four counties indicates that those counties, and perhaps others, need additional guidance and training on screening and documenting reports, including how best to obtain more information about the adults to help make screening decisions.

Lack of Department oversight of screened out reports. The Department does not currently have a process to review reports that are screened out to determine whether counties are making screening decisions in line with statute and rules. According to the Department, it has reviewed some county screen out decisions intermittently in the past but no longer does so because its current practice is to review screened in cases only to assess county compliance with statute and rules after the county begins an investigation. However, the Department does review screened out reports for the child welfare program to assess county compliance. Staff at 10 counties we interviewed told us that Department reviews of screened-in adult protective services cases and screened out child welfare reports have helped them improve their understanding of rules and increase their compliance with them, and that a similar review for screened out reports of adult protective services could help counties

improve screening decisions and documentation. Given the large volume of reports about suspected mistreatment and self-neglect of adults that counties receive annually, a risk-based approach to reviewing screened out reports, such as random samples for each county, would provide the Department with more assurance that counties are screening reports and documenting them appropriately.

INSUFFICIENT CONTROLS OVER REPORT DATE CHANGES. The Department has not implemented controls in CAPS to prevent counties from changing the report date field after a certain amount of time. Program management told us that it thought that CAPS was programmed to prevent counties from changing this field after a report is screened in. Based on our audit work, CAPS is not operating to limit the date changes by counties or prevent counties from entering invalid or inappropriate dates. In addition, the Department does not run and review the CAPS standard report showing historical changes to the dates when counties receive reports. If Program staff conducted a risk-based review of this standard report, particularly for date changes that are weeks or more later than initially entered, it could identify changes that appear to be excessive timeframes for completing screening decisions, and follow up with the counties to ensure that the changes are appropriate and the dates are accurate.

SOME RULES AND GUIDANCE DO NOT ALIGN WITH STATUTORY INTENT. We identified two areas where the Program's written guidance during the period we reviewed, and current rules for screening reports of mistreatment or self-neglect, appear to conflict with the statutory language that counties "shall immediately make a thorough evaluation of the reported level of risk" for each report of mistreatment [Section 26-3.1-103(1), C.R.S.]. Instead of following statutory language to evaluate risk, rules implemented in December 2019 and guidance allow counties to not evaluate the adult's level of risk and screen out a report if, "The only allegation is self-neglect of an adult who has been assessed by [the Program] within the past 6 months, *and*, the adult has a history of refusing services, *and*, there is no reported decline in abilities and/or change in circumstances" [emphasis added].

First, statute contains no language that indicates that the Program can disregard reports about an adult who has a history of refusing services. Department management told us that it has interpreted statute to permit screening out a report if the at-risk adult has a history of refusing services based on the statutory provision that allows the counties to determine "whether an investigation of the allegations is required" [Section 26-3.1-103(1), C.R.S.]. According to the Department, if an adult has a history of refusing services and the county has a reasonable expectation that the adult will not accept services, the rule is meant to prevent the county from infringing on the adult's right to self-determination and allow the county to use its resources on other casework. However, this interpretation can result in counties screening out reports that they would otherwise screen in, which can leave some adults without services.

Second, the 6-month timeline in rule may be too specific to protect at-risk adults. In our review, we identified several instances of an adult's circumstances and health changing significantly in less than 6 months, so this timeframe may be too long to provide adequate protection. For example, one of the at-risk adults in our sample who was allegedly neglected by a caregiver had a report screened out in April 2019 based on a screened out report in March 2019, yet when a third report was made in June 2019, the adult's circumstances had changed significantly, such that the adult needed in-home services and a family member to become power of attorney. According to the Department, the 6-month timeframe is based on another rule requiring the county to conduct a new comprehensive assessment of the adult's abilities every 6 months when a report is screened in and there is an open case, and these assessments provide the counties with sufficient information to identify declines in an adult's abilities. Nonetheless, the rule indicates that the 6-month timeframe only applies when "there is no change in [the adult's] circumstances," which the counties reported can be difficult to determine based on a reported allegation, and counties screened out over 200 reports in Fiscal Year 2019 using this reason.

RECOMMENDATION 4

The Department of Human Services should improve processes for screening reports of alleged mistreatment and self-neglect of at-risk adults by:

A Providing periodic training to counties on screening reports, including the definitions of at-risk adult, mistreatment, and self-neglect, and the reasons for screening out reports and documenting the reasons.

B Programming the Colorado Adult Protective Services system (CAPS) to prevent counties from changing the report date in the system to an invalid or inappropriate date, reviewing report date changes in CAPS after the new programming is in place to ensure that CAPS is functioning as intended, and communicating to counties the allowable reasons to change report dates in CAPS and how to document the changes.

C Implementing reviews of screened out reports to ensure that screening decisions are appropriate.

D Revising rules and written guidance related to allowable reasons for screening out reports to ensure that they align with statutory intent to evaluate reports thoroughly and protect at-risk adults.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department agrees to provide periodic training to counties on screening reports including the definition of at-risk adults, mistreatment, and self-neglect and the reasons for screening out reports and documenting the reasons. The Department will do this

by providing annual refresher training for all caseworkers and supervisors on intake and screening decisions.

B AGREE. IMPLEMENTATION DATE: AUGUST 2020.

The Department agrees to research and implement additional programming changes to CAPS that will further prevent counties from changing the report date for invalid or inappropriate reasons. The Department will also review the report date change after the programming is developed by testing the new validation rule to ensure it is working as designed prior to moving the rule to production in CAPS, as well as testing it after the move to production to verify it is functioning as intended. Finally, the Department will communicate the change, including the acceptable reasons for changing a date and documentation requirements of the same, to counties.

These measures will be added to the processes the Department currently has in place that prevent counties from future dating reports (i.e., entering a report date that is after the date the report is created in CAPS) and also locks the report date field once a report has been screened in or out which require the county to place a CAPS support ticket to change the date at that time. An error in the coding that prevents future dating was identified and corrected during the audit period. The Department will test both of these processes to ensure they are both now working as expected.

C AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department agrees to design and implement a review of screened out reports to evaluate the appropriateness of the decision to screen out the report. In December of 2019, the Department distributed an Informational Memo seeking participation of county staff in a collaborative process for designing and conducting a review of screened out reports of mistreatment of at-risk adults. The Department will continue to design and implement a review process to evaluate screening decisions.

D DISAGREE.

The Department disagrees that the existing rules related to allowable reasons for screening out reports are not aligned with statutory intent to evaluate reports thoroughly and protect at-risk adults. Specifically, the allowable reasons in rule for screening out reports, if selected in CAPS by counties correctly, align with statutory intent. The Department follows all the procedures outlined in the Administrative Procedures Act during rule making, which includes stakeholder feedback, review by the Office of the Attorney General as to the legality and constitutionality of the proposed rules, review and adoption by the State Board of Human Services, and finally, a review by the Office of Legislative Legal Services to determine that the rules meet established standards. The Adult Protective Services (APS) rules passed the review at each step; and therefore, the Department is confident the rules related to screening decisions are in alignment with statute and statutory intent as they are currently written.

The Department relies upon the entire statute when promulgating rules for the implementation of the APS program. As such, the APS program must always balance the need to provide protective services with the adult's right to consent, self-determination, and least restrictive intervention. The rule allowing a report to be screened out because the client has refused services in a recent case was implemented to be respectful of these rights. This reason can only be used when multiple conditions are met.

AUDITOR'S ADDENDUM

The audit found that Program rules and written guidance appear to conflict with statute that requires counties to "immediately make a thorough evaluation of the reported level of risk" for each report of mistreatment [Section 26-3.1-103(1), C.R.S.]. Department rules and guidance allow counties to not evaluate the adult's level of risk and disregard reports about an adult who may be self-neglecting, if that individual has refused services in the past and has been assessed for services in the prior 6 months. Statute does not indicate that the Program can disregard reports for these reasons.

INVESTIGATIONS, ASSESSMENTS, AND SERVICE COORDINATION

When a county screens in a report of mistreatment or self-neglect, it becomes an open case and the county begins an investigation. Counties document their investigations in CAPS and arrange for services for the adult based on the information obtained through the investigation. The Department provides counties written rules, guidance, and training on investigations and service coordination.

During an investigation, the county first attempts to visit the adult in-person to assess their circumstances and interview other individuals with knowledge of the adult's circumstances, such as family, medical workers, and friends, to obtain more information about the adult. Second, the county uses a standard form in CAPS to conduct a comprehensive assessment of the adult's safety risks in the following areas: (1) the type and extent of the mistreatment; (2) whether the adult can perform the activities of daily living including eating, bathing, and dressing; (3) cognition; (4) behavioral concerns; (5) medical needs; (6) home/residence; and (7) financial circumstances. Within each area, the county documents specific factors that impact the adult's health and safety, such as whether the adult can obtain and take medication, make medical decisions, and obtain and use funds for their care. Third, the county uses the evidence collected during the investigation to conclude on a finding for each allegation of mistreatment or self-neglect in the case. The findings are categorized as follows:

- **SUBSTANTIATED**, meaning that "the investigation established by a preponderance of evidence that mistreatment or self-neglect has occurred" [Section 30.100, 12 CCR 2518-1].
- **UNSUBSTANTIATED**, meaning that the investigation "did not establish any evidence that mistreatment or self-neglect has occurred" [Section 30.100, 12 CCR 2518-1].

- **INCONCLUSIVE**, meaning 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" [Section 30.100, 12 CCR 2518-1].

- **UNABLE TO INVESTIGATE**, meaning that the county cannot locate the adult, confirmed that the adult is not at-risk, or the adult has passed away [Sections 30.510.A and 30.660.D, 12 CCR 2518-1]. The county closes these cases.

In Fiscal Year 2019, counties screened in 7,735 reports of mistreatment and/or self-neglect, which included 11,233 different allegations. EXHIBIT 2.6 shows the results of these allegations.

EXHIBIT 2.6. RESULTS OF COUNTY INVESTIGATIONS OF ALLEGATIONS FOR SCREENED IN REPORTS OF MISTREATMENT AND SELF-NEGLECT FISCAL YEAR 2019

Substantiated	2,715
Unsubstantiated	4,038
Inconclusive	2,465
Unable to Investigate	2,015
TOTAL ALLEGATIONS	11,233

SOURCE: Office of the State Auditor analysis of data from CAPS.

Even if the county determines that the allegation is unsubstantiated or inconclusive, it may develop a case plan if the assessment of the at-risk adult identifies that services are needed to mitigate the adult's identified risk areas. For example, if the county finds that the adult can remain in their home but needs help with completing activities of daily living, the case plan could include that the county coordinate home health care for the adult. Once the adult begins receiving the services in their plan, the county determines whether the services meet the adult's needs, and if so, the county closes the case.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

The purpose of the audit work was to evaluate whether counties

investigate cases and coordinate services in line with statute, rules, and Program guidance, and in a manner that improves the safety of at-risk adults. We analyzed aggregate data for the 7,735 screened in reports in Fiscal Year 2019 to identify: (1) the adults who had the most cases about them during the year and (2) the alleged perpetrators who had the most cases alleging mistreatment during the year. We selected two groups of cases to review, as follows:

- A random sample of 45 cases.
- 58 cases for the three adults and three alleged perpetrators with the most cases during that year.

In total, we reviewed 103 cases that had been screened in across 18 counties. We also reviewed the results of desk reviews conducted by Program staff and Department quality assurance reviews that assessed county compliance with rules for Fiscal Year 2019. We interviewed staff and supervisors at a sample of 10 counties and Program management and staff to understand county processes for investigations, assessments, service coordination, and case closure.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

We reviewed county processes for investigations, assessments, service planning and coordination, and case documentation, as well as the Department's oversight of these processes, to assess compliance with the requirements described below, which included the rules in place during the period of our review.

INVESTIGATIONS by counties are to be conducted as follows:

- **DETERMINE FINDINGS RELATED TO ALL ALLEGATIONS.** When the county confirms that the adult is at-risk, it must conduct an investigation to determine findings related to allegations of mistreatment or self-neglect. The investigation must include "making a finding regarding the substantiation or unsubstantiation

of the allegations [and]…the perpetrator(s) of the mistreatment," [Sections 30.520.7 and 30.520.8, 12 CCR 2518-1]. Allegations are to be substantiated by a preponderance of evidence, meaning "credible evidence that a claim is more likely true than not" [Section 30.100, 12 CCR 2518-1]. The investigation "must address the specific allegations identified in the report as well as any new mistreatment or self-neglect that may be identified during the investigation" [Section 30.510.A.4, 12 CCR 2518-1].

- **CONDUCT INTERVIEWS.** Rules require the counties to make reasonable efforts to interview the adult and the alleged perpetrator, and if counties cannot conduct these interviews, they are required to document in CAPS the reasons they are unable to do so [Sections 30.510.A and 30.520.A, 12 CCR 2518-1]. However, rules do not define what actions would constitute "reasonable efforts."

ASSESSMENTS are to be conducted by counties, as follows:

- **ASSESSMENTS SHOULD BE COMPLETE AND TIMELY.** During initial contact with the adult, the county shall begin an assessment of the adult's risk, safety, strengths, and immediate needs for services [Sections 30.510.B and 30.530.A, 12 CCR 2518-1]. Counties must complete and document the assessment, including "all impacts and mitigating services," in CAPS "within 45 calendar days of the receipt of the report" [Section 30.530.C, 12 CCR 2518-1]. According to the Department, impacts are difficulties or impairments for the adult, such as the inability to manage their medications or bathe on their own.

- **USE ASSESSMENTS TO DETERMINE IF THE ADULT IS AT-RISK.** The county must conduct a thorough and complete investigation into the allegations if the assessment confirms that the adult is at-risk [Section 30.510.A, 12 CCR 2518-1]. According to Program management, key areas of the assessment that are to be used to determine whether an adult is at-risk relate to activities of daily living, cognition, behavioral concerns, and medical. After the assessment determines that an adult is at-risk, the county shall develop a case plan for protective services based upon the

investigation and assessment, unless the allegations are unsubstantiated and there is no other identified need [Sections 26-3.1-103(1), C.R.S., and 30.610.D, 12 CCR 2518-1].

SERVICE COORDINATION should include:

- **CASE PLAN DEVELOPMENT.** Counties are required to "complete and document the case plan within 45 calendar days of the receipt of the report" or document the reason they are unable to do so [Section 30.610.D, 12 CCR 2518-1]. A case plan should include "the person responsible for arranging each identified service need" and "the status of all identified service needs" [Sections 30.610.C.2 and 30.610.C.3, 12 CCR 2518-1].

- **MAINTAINING CONTACT WITH THE AT-RISK ADULT.** Counties are required to "maintain ongoing contact [with the adult] as long as the case is open" and "face-to-face [adult] contact shall occur at least once every month, not to exceed 35 calendar days from the last face-to-face contact" [Section 30.620.E, 12 CCR 2518-1].

CASE DOCUMENTATION. Counties are required to document all report and case information in CAPS, and documentation shall include all aspects of the case, including the initial report, investigation, assessment, and case plan [Section 30.260.A, 12 CCR 2518-1], as well as attaching to the case in CAPS any supporting documents "critical to the [adult protective services] case record," including the adult's power of attorney, police and facility incident reports, medical records, and bank or other financial records [Sections 30.520.A.6 and 30.260.B.2, 12 CCR 2518-1]. Additionally, timelines for documentation are as follows:

- Counties must enter reports directly into CAPS within 1 business day of receipt or should document the reason if unable to do so [Section 30.410.C, 12 CCR 2518-1].

- All interviews, contacts, or attempted contacts with the adult, alleged perpetrators, and other contacts during the investigation shall be documented within 14 calendar days of receipt of the information [Section 30.520.B.1, 12 CCR 2518-1].

WHAT PROBLEMS DID THE AUDIT IDENTIFY AND WHY DO THEY MATTER?

Overall, we identified problems in each area of the investigation process and for 11 of the 18 counties reviewed. Altogether, 24 of the 103 cases we reviewed (23 percent) had one or more problems with county investigative processes, assessments, service coordination, and/or case documentation that did not follow statute, rules, and/or guidance, as follows:

INVESTIGATIONS. We identified 11 cases where the county did not adhere to requirements for investigating a report:

- **FAILURE TO INVESTIGATE.** Four cases were closed improperly by the counties without investigating allegations of financial exploitation. One case was closed with a finding of "Unable to Investigate/Not Required" in CAPS but the case file showed enough evidence to warrant an investigation, including a reference to a police report about the alleged perpetrator and notes that another county was investigating the same alleged perpetrator for financial exploitation of nine other adults. The second case was closed improperly when the county determined that it did not need to investigate the financial exploitation allegations and that the adult did not need services. The county wrote "Unable to Investigate/Not Required" in CAPS, although the county would have had sufficient evidence to substantiate the allegations because it involved one alleged perpetrator who was part of multiple investigations for financial exploitation of multiple at-risk adults. In two other cases involving financial exploitation by a single alleged perpetrator, the counties did not investigate additional allegations of exploitation identified during the investigation. For example, in one case, CAPS showed that the initial report involved an allegation that the adult's guardian was billing for more time than was actually spent with the adult. When the county spoke with the adult, it documented in CAPS a concern related to the guardian's stewardship of the adult's belongings but did not add this allegation of exploitation to the case or investigate it.

- **POTENTIAL FAILURE TO INVESTIGATE.** For two cases that each involved two related adults in the reports, the counties did not determine whether an investigation was required for the second adult. One case involved two siblings with intellectual developmental disabilities who needed housing assistance when their caretaker passed away, and the other case involved a married couple who had allegedly been financially exploited. In both cases, the county conducted an investigation for only one of the adults; the second adult in each case was not screened to determine whether they were at-risk and would need an investigation.

- **INCOMPLETE INVESTIGATION.** For one case involving an allegation of financial exploitation of an at-risk adult, the county's finding was that the evidence was inconclusive, yet the county did not conduct a thorough investigation. According to CAPS, the alleged perpetrator claimed to have a legitimate reason for spending the adult's funds to repay a debt and was willing to provide financial documents; however, the county did not obtain the relevant financial records or interview relevant family members.

- **INACCURATE FINDINGS.** In one case, the evidence in the case files did not appear to support the county's findings. The county's finding was inconclusive, but the case file showed that two people witnessed the mistreatment of the at-risk adult and confirmed that physical abuse occurred.

- **NO INTERVIEWS OF THE ALLEGED PERPETRATOR OR AT-RISK ADULT.** In two cases, counties did not interview the alleged perpetrator and in a third case, the county did not interview the adult. In these three cases, the counties did not appear to make reasonable efforts to conduct the interviews or document why they could not conduct them. Notes in CAPS for one case showed that the county left one voicemail with the facility where the alleged perpetrator worked and made no other attempts to conduct an interview. For the second case, in which the alleged perpetrator lived with the at-risk adult, CAPS notes showed the county made three attempts to reach the alleged perpetrator by phone but never attempted to visit the home. In the third case, the

county received information that the adult was at a homeless shelter, but there was no indication in CAPS that the county attempted to visit or contact the homeless shelter. Program management agreed that these attempts did not meet its expectations for "reasonable efforts."

When counties do not complete all steps required for an investigation, including investigating all allegations, there is a risk that counties will not make accurate findings with respect to determining whether adults were mistreated. When counties do not make findings that are supported by the evidence, the alleged perpetrators may not be held accountable for mistreatment or conversely, counties may incorrectly substantiate that an individual is a perpetrator when they are not.

ASSESSMENTS. We identified four cases where the counties did not adhere to one or more of the requirements related to assessments:

- **ASSESSMENTS NOT CONDUCTED OR WERE INCOMPLETE.** In one case, the county did not conduct an assessment, as required, despite interviewing the at-risk adult prior to him moving out of the county. According to Program management, case notes had enough information for the county to document an assessment "at least partially" because the notes included information from the adult, the adult's family and social worker, and medical staff. According to Program management, the case note information could have been used by the county to complete sections of the assessment such as the adult's situation at home, ability to perform activities of daily living, and cognitive abilities. In a second case, the county did not complete all impacts in the assessment, as required by rule. Specifically, the county did not complete the home/residence section of the assessment, which involves visiting the adult at their home, although the alleged mistreatment occurred at the adult's home. This section is needed to identify any safety risks in the home such as lack of utilities and food availability.

- **INCORRECT DETERMINATION OF ADULT'S AT-RISK STATUS.** In one case, there were multiple allegations of self-neglect, caretaker

neglect, and financial exploitation of an adult. The county incorrectly concluded that the adult was not at-risk and closed the case without investigating or coordinating services for the adult, despite the assessment showing that the adult was at-risk based on having multiple significant impacts in cognition, including requiring consistent or multiple prompts to complete activities of daily living, inability to process information, and inability to understand the consequences of their actions.

- **UNTIMELY ASSESSMENT.** In one case, the county did not complete the assessment within the required 45 calendar days but took a further 22 days past the deadline.

When counties do not thoroughly conduct and document an assessment, there is a risk that case planning will not be based on complete information about the adult's situation. For example, if the county does not complete the full assessment, including the home/residence section, the adult could potentially be living in unsafe conditions and the county would not be aware. When completed assessments are not used to determine the adult's at-risk status, it can result in the adult not receiving the services they need. For example, in the case above involving multiple allegations of self-neglect and mistreatment of one adult, the adult had documented medical needs and may have needed services such as home health services and medical assistance, but the county closed the case without coordinating any services. When assessments are untimely, it can result in a delay in case planning and in implementing protective services.

SERVICE COORDINATION. We identified five cases where the counties did not adhere to one or more of the requirements for coordinating services:

- **UNTIMELY CASE PLAN.** In one case, the county created the case plan 35 days later than the required 45 calendar days and did not document the reason the plan was untimely. This case involved an at-risk adult who needed housing assistance.

- **SERVICE STATUS OR PERSON ARRANGING SERVICES NOT**

DOCUMENTED. In the same case described above, the county did not update the status of a service in the case plan, as required. The county helped the adult's caretaker apply for housing assistance, but the case plan and notes did not indicate the status of this service so it was unclear whether the adult received the service. For three other cases, the case plans did not identify the person responsible for arranging the services, which included medical rehabilitation and in-home care.

- **UNTIMELY FACE-TO-FACE VISIT.** In one case, the county visited the adult 4 days later than the required 35 calendar days. This case involved an at-risk adult who was found to have been financially exploited by a family member and who needed to be placed in an independent senior community because of an unsafe home.

When counties do not prepare timely and thorough case plans, there is a risk that the adult will not receive services necessary to ensure their safety, when they need them. When the county does not conduct a timely visit with an at-risk adult, the county may not be aware of whether services are addressing the adult's needs or whether the adult has developed additional needs that require different services.

CASE DOCUMENTATION. We identified 10 cases where the counties did not adhere to one or more of the requirements for case documentation:

- **MISSING DOCUMENTATION OR CASE NOTES.** Seven of the cases we reviewed lacked documents or notes that rules require be included in CAPS, as follows:

  - Two cases had case notes referring to law enforcement investigations or a facility's investigation of an incident, but these reports were not in the case files.

  - In two cases, the adult had a power of attorney, but these documents were not in CAPS.

  - One case had notes in CAPS stating that the adult had a medical evaluation and was diagnosed with a disease relevant to the case and service plan, but the medical records were not in CAPS.

- One case had a case note in CAPS stating that the alleged perpetrator was willing to provide financial records that were relevant to the investigation of allegations of financial exploitation, but these records were not in CAPS.

- In one case, the county did not list one of the adult's parents, with whom the adult lived, as an individual who could provide support for the adult.

The counties did not document that they were unable to obtain the missing documents or that there was good cause for the lack of these documents or case notes in CAPS.

- **Untimely documentation.** One report of an allegation was not entered within 1 business day from when it was received, as required; it was entered 15 days late. Two other cases had case notes describing interviews or contacts that were entered 19 days and 23 days later than the 14-calendar day deadline, respectively.

When counties do not thoroughly document investigations in CAPS, they may not be able to demonstrate that substantiated findings meet the evidentiary standard of a preponderance of evidence. As discussed in the section "Outcomes of Appeals for Perpetrators," when substantiated perpetrators appeal a finding, the Department reviews the case to evaluate whether the county substantiated the finding based on a preponderance of evidence and must rely on this evidence to decide the appeal. If counties fail to document the investigation thoroughly and accurately, it increases the risk that substantiated findings may be overturned through an appeal. Complete and thorough case file documentation is also needed to maintain a historical record of the mistreatment and parties involved. Without complete documentation, the county may not be able to determine whether the mistreatment is reoccurring. When some documentation is not completed in a timely manner, there is a risk that county staff will not recall the complete and accurate details of the investigation in order to document the case.

At our request, Program management and staff reviewed each of the 24

cases for which we identified problems and agreed with each of the instances we found in which the counties did not adhere to the requirements in statute, rules, and guidance.

In addition, the Program staff's desk reviews and the Department's quality assurance reviews (QA reviews), which are conducted by the Administrative Review Division (ARD), have found problems with county investigations that are similar to what we found. Specifically, for Fiscal Year 2019, the Program staff's desk reviews assessed compliance with rules for findings categorized as "Unable to Investigate" for the 35 counties that had those findings, which included 16 of the 18 counties that we reviewed. The desk reviews found that for 28 percent of the findings, the counties, including seven of the 11 where we identified problems, had inappropriately made a finding of "Unable to Investigate" when an investigation was warranted. According to quarterly training materials that Program staff provided to counties, the majority of these findings were noncompliant because "reasonable efforts to investigate were not exhausted." In Fiscal Year 2019, ARD conducted QA reviews of compliance with rules for investigations for 43 of the counties, which included 12 of the 18 counties that we reviewed. The QA reviews sampled cases that had been closed to evaluate investigations and the initial assessment of risk, safety, and needs; and sampled cases involving at-risk adults receiving services to evaluate service planning and provision, the final assessment of safety improvement, and case closure. ARD's QA reviews identified areas needing improvement for eight of the 11 counties where we identified problems and in many of the areas that we identified, including county findings that were not supported by evidence; failure to conduct interviews of alleged perpetrators; lack of identifying services for the adults; and lack of supporting documentation, such as medical and financial records and applicable fiduciary documents.

WHY DID THESE PROBLEMS OCCUR?

MORE OVERSIGHT, GUIDANCE, AND TRAINING NEEDED. The problems we identified can be attributed primarily to some gaps in Department oversight and enforcement. Specifically:

- **DESK AND QA REVIEWS DO NOT INVOLVE PERFORMANCE IMPROVEMENT PLANS OR OTHER PROCESSES TO ENSURE THAT PROBLEMS ARE ADDRESSED.** Although the desk and QA reviews can help the counties understand and comply with rules, the Department does not require counties to prepare and submit performance improvement plans for addressing the problems identified and hold counties accountable for noncompliance. Furthermore, the Department does not conduct follow-up procedures to determine whether the counties have addressed and corrected the issues identified through the reviews.

- **AGGREGATE DATA ON THE RESULTS OF QA REVIEWS HAVE NOT BEEN CONSISTENTLY ANALYZED TO IDENTIFY COMMON PROBLEM AREAS ACROSS COUNTIES.** The Department has not regularly compiled the data results from QA reviews to analyze trends in areas needing improvement statewide. At the end of our audit, QA review staff at the Department told us that they had begun compiling aggregate statewide data on the results of QA reviews and provided the data to Program staff for use in determining statewide trends and facilitating discussion on potential factors impacting each area of improvement; however, this type of aggregate analysis was not conducted during the timeframe covered by the audit. Implementing a process to compile and analyze statewide QA review results on a regular basis, such as annually, would allow the Department to identify common areas of non-compliance and take steps to help address them, such as by tailoring training to address the most commonly occurring areas needing improvement.

- **NEED FOR MORE TARGETED TRAINING.** The problems that Department desk and QA reviews have identified, and that we identified, indicate that at least the counties with problems need more training on investigations, assessments, service coordination, and documentation. House Bill 17-1284 [Section 26-3.1-103(1.5), C.R.S.] specifically requires the Department to train counties on conducting investigations to ensure consistency, and according to Department management, they requested this provision to improve the overall

quality of investigations. In 2018, the Department provided county caseworkers and supervisors a required 3-day training on investigations, and a separate training on assessments, developing case plans, and documenting casework, and continues to provide this training to new county caseworkers and supervisors. Program staff also provide ongoing optional training to counties on these topics through quarterly webinars, meetings, and written memos. Nonetheless, staff in some of the counties for which we identified problems told us that the Program's training can be lacking or inconsistent and that they would benefit from more targeted training to address the types of problems identified in the audit, including on investigations involving self-neglect, assessments, and the relevancy of supporting documentation. In the two cases for which the counties only conducted an assessment for one of the two related at-risk adults, the counties could use additional training on how to create separate cases, with unique assessments and service plans, for reports that reference two at-risk adults.

Further, with no regular analysis of QA review results in aggregate, the Program's training is not as targeted as it could be to address problems. Using the results of QA reviews would allow the Department to identify not only noncompliance issues that are common to multiple counties, but also whether counties with certain characteristics (e.g., those in rural areas, those with small numbers of adult protective services cases) would benefit from more training. For example, some staff in counties that have very few adult protective services cases each year told us that they could use more guidance through training on investigations because they have limited experience with these types of cases.

- **Additional guidance and training needed to clarify rules for investigation interviews.** Rules [Section 30.510, 12 CCR 2518-1] do not define which actions would constitute "reasonable efforts" to conduct interviews with the adults and alleged perpetrators during investigations. Clarification of the meaning of "reasonable efforts" in written guidance and training would provide

counties with direction on what steps should be taken to conduct these interviews and what needs to be documented when the interviews cannot be conducted.

RECOMMENDATION 5

The Department of Human Services should improve county investigations of allegations of mistreatment or self-neglect of at-risk adults, which are conducted through the Adult Protective Services Program (Program), by:

A Implementing processes to ensure that counties address the problems identified through desk and quality assurance reviews. This should include a performance improvement process and follow-up to help ensure county compliance.

B Continuing to compile data on statewide trends in deficiencies identified through quality assurance reviews, implementing a process to analyze the data regularly to identify common areas for improvement, and utilizing the information to develop additional guidance and training for counties and improve Program operations.

C Developing targeted training to address the problems identified in this audit and for the counties identified as noncompliant with statute, rules, and guidance.

D Clarifying in written guidance and training, the actions that would constitute "reasonable efforts" to conduct interviews with the adults and alleged perpetrators during investigations.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department agrees to implement a process to ensure counties address problems identified through the Department's quality assurance reviews that includes a performance improvement process and follow up to help ensure county compliance.

B AGREE. IMPLEMENTATION DATE: SEPTEMBER 2020.

The Department agrees that routine analysis of the data from quality assurance reviews could assist the Program in identifying training needs within individual counties, regions, or statewide. The Department will continue to compile data on statewide trends in deficiencies identified through quality assurance reviews. The Department will use the data to implement a supplemental process to analyze this data, in conjunction with current data analysis, to regularly identify common areas for improvement. The Department will incorporate the new analysis into the current process that utilizes data analysis to develop additional guidance and training for counties and improve Program operations.

C AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department agrees with this recommendation and will develop and implement targeted training to address problems identified in the audit which will be provided statewide. For counties identified through the audit as non-compliant with requirements, the Department will provide training to improve compliance in those areas.

D AGREE. IMPLEMENTATION DATE: DECEMBER 2020.

The Department agrees with this recommendation and will clarify in written guidance actions that would constitute "reasonable efforts" to conduct interviews with clients and alleged perpetrators during investigations. In addition, the Department will provide guidance on this annually through training, including Training Academy for new caseworkers and supervisors, and through quarterly training meetings.

DOCUMENTATION OF COUNTY GUARDIANSHIPS OF AT-RISK ADULTS

Under certain circumstances, county departments of human/social services are appointed by the court as guardians of at-risk adults. In accordance with statute, a county is "urged to" petition for guardianship and/or conservatorship of an at-risk adult if a county investigation finds mistreatment or self-neglect of the adult who lacks the capacity to make decisions and has no family member, friend, or other appropriate person to oversee their care [Section 26-3.1-104(2), C.R.S.]. A guardian makes decisions regarding the adult's support, care, health, and welfare, as necessitated by the adult's limitations and as stated in a court order [Section 15-14-314, C.R.S.]. A conservator manages and expends the income and assets of the protected adult's estate [Section 15-14-418, C.R.S.].

When a county determines that an at-risk adult needs a guardian or conservator, the county first attempts to identify a family member, friend, other person, or organization who could be the guardian, before it petitions itself. If no other person or organization is identified, counties can petition the court for emergency temporary guardianship or permanent guardianship, depending on the at-risk adult's needs. Unless the adult already has a conservator or does not need one because he or she does not have income or assets, county guardianship typically includes the county being given authority to manage the adult's finances to make sure that their income and assets are used for their care needs. Emergency temporary guardianship lasts up to 60 days, while permanent guardianship lasts until the adult dies or the court order changes [Sections 15-14-312 and 15-14-318, C.R.S.]. Program rules specify requirements that counties must follow when determining whether guardianship is needed and documenting these cases in CAPS [Section 30.260, 12 CCR 2518-1].

In Fiscal Year 2019, there were 30 counties in Colorado that held a total

of 479 adult guardianships—115 were new temporary or permanent guardianships and 364 began prior to Fiscal Year 2019. EXHIBIT 2.7 shows the number of adult guardianships held by each county in Fiscal Year 2019.

EXHIBIT 2.7. COUNTY-HELD GUARDIANSHIPS OF AT-RISK ADULTS, FISCAL YEAR 2019

COUNTY[1]	NEW TEMPORARY GUARDIANSHIPS	NEW PERMANENT GUARDIANSHIPS	CONTINUED GUARDIANSHIPS	TOTAL
Denver	25	33	140	198
Jefferson	7	11	49	67
Arapahoe	2	3	28	33
Mesa	3	4	16	23
Larimer	1	1	13	15
Adams	0	0	14	14
Boulder	4	1	8	13
Morgan	0	2	10	12
Pueblo	2	0	9	11
La Plata	1	1	9	11
Fremont	0	0	10	10
Teller	2	0	8	10
Alamosa	0	1	9	10
Montezuma	3	0	4	7
Archuleta	2	0	4	6
Delta	1	0	4	5
Las Animas	2	1	2	5
Logan	0	0	5	5
Garfield	0	0	4	4
Washington	0	0	4	4
Sedgwick	0	0	3	3
Huerfano	0	0	2	2
Kit Carson	0	0	2	2
Weld	0	0	2	2
Yuma	0	0	2	2
Chaffee	0	0	1	1
Dolores	1	0	0	1
Gilpin	0	0	1	1
Park	1	0	0	1
Prowers	0	0	1	1
TOTAL	57	58	364	479

SOURCE: Office of the State Auditor analysis of data from CAPS.

[1] The following counties did not become guardians or have continued guardianships during Fiscal Year 2019: Baca, Bent, Broomfield, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Douglas, Eagle, El Paso, Elbert, Grand, Gunnison, Hinsdale, Jackson, Kiowa, Lake, Lincoln, Mineral, Moffat, Montrose, Otero, Ouray, Phillips, Pitkin, Rio Blanco, Rio Grande, Routt, San Jan, San Miguel, and Summit.

WHAT WAS THE PURPOSE OF THE AUDIT WORK AND WHAT WORK WAS PERFORMED?

We evaluated the counties' processes for becoming guardians of at-risk adults to determine whether permanent guardianships addressed the adults' safety needs in the least restrictive manner. We selected a random sample of 15 of the 58 new permanent county guardianships that began during Fiscal Year 2019 and reviewed the documentation in CAPS for the sampled cases. For seven of the 15 sampled county guardianships, the county was also the conservator, or was made a representative payee for the adult by the Social Security Administration, because the adult had income or assets; for these cases we reviewed documentation showing how the counties established trust accounts for the at-risk adults. We also reviewed aggregate data for all guardianships in Fiscal Year 2019, including key dates of when the counties became the adults' guardians, and the Program's policies and training documents provided to counties. We interviewed Program management and staff, and staff in 10 counties to understand the process for petitioning the court for guardianship and the county's role after it becomes a guardian.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

COUNTIES MUST DOCUMENT IN CAPS THAT GUARDIANSHIP IS NEEDED, IN LINE WITH STATUTES AND RULES. Rules state that "prior to reaching a decision to petition the court for guardianship or conservatorship, the county department shall ensure that the following factors are met and have been documented" [Section 30.630(A.1), 12 CCR 2518-1]:

The protective services provided constitute the least restrictive intervention [Section 26-3.1-104(3), C.R.S.]. Least restrictive means "the shortest duration and to the minimum extent necessary to remedy or prevent situations of actual mistreatment, self-neglect, or exploitation" [Section 26-3.1-101(6), C.R.S.].

- Court intervention will resolve safety concerns and no other method of intervention will meet the adult's needs [Sections 30.630(A.1.a and b), 12 CCR 2518-1].

- The county does not seek guardianship solely to make medical decisions, but to address all aspects of an at-risk adult's needs [Section 30.630(A.1.c), 12 CCR 2518-1].

- Court intervention is warranted by either: (1) the degree of the adult's incapacity, as supported by medical or psychiatric evidence, and the degree of risk, as supported by investigative evidence, or (2) the suspected incapacity of the adult and degree of risk, as supported by investigative evidence [Sections 30.630(A.1.d.i and ii), 12 CCR 2518-1].

- There is an absence of other responsible parties, such as family or friends, able or willing to petition the court for guardianship [Sections 26-3.1-104(2), C.R.S., and 30.630(B), 12 CCR 2518-1].

COUNTIES MUST FOLLOW STEPS TO ENSURE THAT GUARDIANSHIP WILL BE APPROPRIATE AND THAT THE ADULT'S ASSETS ARE PROTECTED. If the planned guardianship meets each of the requirements listed above, the county must then follow these key steps during the process of petitioning the court and becoming guardian:

- The county shall consult with an attorney prior to filing a petition and throughout the process [Section 30.630(B.1), 12 CCR 2518-1]. According to Program management, the purpose of the consultation with an attorney is to ensure that (1) the county receives legal advice, such as about other options to guardianship and the legal ramifications of guardianship; (2) there is enough evidence to meet the legal standards for guardianship; and (3) the attorney agrees with the recommendation to petition for guardianship, both prior to filing a petition with the court and during court proceedings.

- When a county is appointed by the court to act as guardian, the county shall maintain in CAPS court documents and reports, including the court order appointing the county as guardian, county

follow-up reports about the adult submitted to the court, and other documents presented by the county as evidence to support the decision to seek guardianship, such as medical documentation; and the county shall update the case record in CAPS to reflect these documents [Section 30.630(B.4), 12 CCR 2518-1].

- If the county becomes the permanent guardian with financial responsibility or the conservator for the adult, the county is required to establish a trust account for the adult with the county department as trustee [Sections 30.645(A and B), 12 CCR 2518-1].

Program management told us that although there are no written rules or guidance on what types of case notes or documents are needed in CAPS to satisfy the documentation requirements for guardianships, counties are trained to document cases, including the at-risk adult's needs, county observations and decisions, and case planning. Program management said that there is an expectation that if something is not documented, it did not happen.

WHAT PROBLEMS DID THE AUDIT IDENTIFY?

Overall, we found one or more problems with all 15 sampled guardianship cases that demonstrate inconsistent, and at times noncompliant documentation practices, among the sampled counties that hold guardianships of at-risk adults. We did not identify issues with how counties established trust accounts in the seven sampled cases where the county had conservatorship or was a representative payee. Although we did not identify any guardianships that appeared unnecessary, we could not verify that the counties adhered to all applicable documentation requirements for the sampled guardianships.

First, we could not determine whether the counties followed statute and rules in seeking guardianships for 14 of the 15 cases sampled (93 percent) because the counties lacked sufficient documentation of their processes and decision-making. For the 14 guardianships, which were in five different counties, there was a lack of case notes and

documentation in CAPS with clear statements showing that the county actions met the requirements for becoming the adult's guardian. The only documentation that the counties consistently maintained related to guardianships was that the adult's incapacity and degree of risk were supported with letters from the adults' doctors and investigative evidence. EXHIBIT 2.8 summarizes the required documentation that was not sufficient for each of the 14 cases.

EXHIBIT 2.8. SUMMARY OF INSUFFICIENT DOCUMENTATION IN CAPS FOR 14 SAMPLED COUNTY GUARDIANSHIPS

SAMPLED CASE	INSUFFICIENT EVIDENCE GUARDIANSHIP WAS THE LEAST RESTRICTIVE INTERVENTION	INSUFFICIENT EVIDENCE GUARDIANSHIP WOULD SOLVE SAFETY CONCERNS AND NO OTHER INTERVENTION MET ADULT'S NEEDS	INSUFFICIENT EVIDENCE GUARDIANSHIP NOT SOUGHT SOLELY TO MAKE ADULT'S MEDICAL DECISIONS	INSUFFICIENT EVIDENCE THAT NO OTHER RESPONSIBLE PARTY COULD BECOME GUARDIAN
Case 1	●	●	●	
Case 2	●	●	●	
Case 3	●	●	●	
Case 4	●			
Case 5	●			
Case 6	●			
Case 7	●	●		
Case 8	●			
Case 9	●			
Case 10	●	●	●	
Case 11	●	●	●	●
Case 12	●	●	●	
Case 13	●	●	●	●
Case 14	●			
TOTAL	14	8	7	2

SOURCE: Office of the State Auditor analysis of data from CAPS.

Examples of the problems we identified related to documentation of county guardianship cases include the following:

- In Case 2, the case file contained insufficient written comments by the county describing how it determined that seeking county guardianship was the least restrictive intervention, was the only means of solving the adult's safety needs, or was not sought solely to make the adult's medical decisions, nor was there other documentation demonstrating how the county had considered these

criteria when deciding to pursue guardianship. Program management told us that the fact that the county had been granted temporary guardianship was sufficient; however, the existence of the temporary guardianship does not provide evidence that the county considered all the criteria in statute, and the county did not sufficiently document its considerations, as required in rule. The Program appeared to agree with the lack of sufficient documentation, telling us that, the information in the case file only supported that the guardianship was "*potentially* [emphasis added] the sole route of helping the [adult] meet [their] needs."

- In Case 7, the case file contained insufficient written comments describing how it determined that county guardianship was the least restrictive intervention, was the only means of solving the adult's safety needs, and was not sought solely to make the adult's medical decisions, nor was there other documentation demonstrating how the county had considered these criteria when deciding to pursue guardianship. Program management told us that it believed that the case file had "ample information" in case notes from interviews with the adult and the adult's coworker, and a letter from the hospital and related case notes. However, these cases notes, interviews, and letter did not provide evidence that the county had evaluated whether assistance other than a county guardianship was the only option to address the adult's needs. Program management told us that it believed "the guardianship [court] orders themselves support that there is not a less restrictive means of assisting the [adult] and that the [adult's] incapacity is such that guardianship is needed to ensure safety." Court orders of the guardianship do not demonstrate that the counties followed the criteria in rule when deciding to become guardian.

- In Case 11, the case file contained insufficient written comments by the county, and no other documentation, that the guardianship was the least restrictive intervention and that the county sought other responsible parties who could serve as guardian, even though case notes stated that the adult had a brother who made the adult's

> medical decisions as well as had a conservator. The file had no evidence that the county tried to contact either person to discuss becoming the adult's guardian. Program management told us that "the guardianship orders…specifically state that the court has determined less restrictive means cannot meet the [adult's] needs," which does not demonstrate that the county made this determination prior to seeking guardianship, as rules require.

For the two cases with insufficient evidence that no other responsible party could become guardian, the counties did not document that they attempted to identify any other individuals to be the adult's guardian before petitioning for guardianship. For example, in one case, the county had substantiated an adult's parents for caretaker neglect and tried to help the parents improve their adult child's care, but the county obtained guardianship of the adult, without any indication in the case file that the county had sought anyone else to care for the adult. In contrast, 13 guardianships in our sample had case notes in CAPS that clearly demonstrated the counties' attempts to identify other responsible parties; for example, the county caseworkers documented that they had contacted the adult's relatives about becoming the guardian prior to the county becoming that adult's guardian, and that those relatives had declined.

In contrast to the 14 cases in EXHIBIT 2.8 and the examples above, one sampled case had documentation in CAPS showing that the county had considered all of the criteria before seeking guardianship. In this case, the county had a specific statement that the caseworker had determined "that guardianship and [skilled nursing facility] placement are the least restrictive means to keep the [adult] safe." The case file included a narrative summary of how the county considered all of the adult's needs including medical, that the adult lacked capacity due to advanced dementia, that the adult's family member was an "unreliable and inappropriate caregiver," and that there was no other responsible party who could be guardian. The case file also noted that the county attempted to contact another relative to become the guardian but the relative did not respond.

According to the Department, the fact that a judge granted guardianship in all cases we sampled means that the county guardianships met all the criteria in statute and rules. Program management told us that in some cases "the guardianship [court] orders themselves support that there is not a less restrictive means of assisting the [adult] and that the [adult's] incapacity is such that guardianship is needed to ensure safety." However, it is not the court's responsibility to evaluate whether the counties follow Department rules and documentation requirements when they petition for guardianship. The court's decision is based on its determination that sufficient evidence was presented to warrant its assignment of a guardian. For example, the court order in one case we reviewed explained that the guardianship was appropriate, not because all the statutory elements had been determined by the county, but because, "[The adult] has significantly impaired cognitive functioning and is unable to make decisions regarding [their] health and safety."

Second, we could not verify that counties consistently followed some of the key steps outlined in rules. Specifically, we found:

- **INSUFFICIENT DOCUMENTATION AND NOTES TO DEMONSTRATE THAT THE COUNTY CONSULTED AN ATTORNEY.** Eight of the sampled guardianships (53 percent) did not have evidence in CAPS to show that the county had discussed becoming the adult's guardian with an attorney prior to petitioning the court for guardianship, as required by rules. In seven of these cases, information in CAPS showed that the county consulted an attorney *after* the guardianship petition was filed with the court; while in the remaining case, there was no documentation that the county consulted an attorney at any point. According to Program management, "there is a reasonable assumption that an attorney was consulted" in these cases because an attorney files the petitions and attends the hearings, but CAPS did not reflect any attorney's involvement, including attending the court hearings. By contrast, the seven sampled cases that had documentation of county consultations with an attorney prior to petitioning included case notes explaining that caseworkers contacted the county attorney for advice and information needed to

file a petition for guardianship, which demonstrates the inconsistency in county documentation of attorney consultations.

- **CAPS DID NOT INCLUDE SOME RELEVANT COURT DOCUMENTS.** For four of the sampled guardianships (27 percent), the counties did not maintain some of the court documents in CAPS, as rules require. In three cases, the signed court documents that granted the county guardianship of the adult were not in CAPS. In the fourth case, the annual guardianship report that the county was supposed to submit to the court was not in CAPS. After we brought these problems to the Department's attention, Program staff followed up with the counties, which then saved the court documents in CAPS.

WHY DID THESE PROBLEMS OCCUR?

Overall, the problems we identified occurred because the Department has not promulgated guidance for counties or processes to help ensure that counties comply with statute and rules. Specifically:

LACK OF GUIDANCE ON GUARDIANSHIPS FOR COUNTIES. While the Department provides counties guidance on case file documentation for reports of mistreatment, screenings, investigations, and case planning, and emphasizes overall documentation thoroughness for any actions taken in a case, it has not provided counties guidance for documenting the process and basis for county decisions when seeking guardianship. For example, there has been no direction, such as through written guidance or training, on the type of documentation needed in CAPS for a county to demonstrate that it fulfilled the requirements for guardianship, including the documentation needed to show this service is the least restrictive intervention, would resolve safety concerns, and that no other intervention would address the adult's needs. Written guidance and training could include direction that the county must document in CAPS how it determined the extent of the guardianship needed, that the guardianship was the least restrictive and would solve safety concerns, and that no other services could be provided to the at-risk adult, besides county guardianship, which would successfully address the adult's needs. In addition, there is no guidance for how

counties should identify and document the search for other responsible parties, such as family or friends, who could be willing to become the adult's guardian. Written guidance and training could include direction that the county must narrate in CAPS the attempts that were made to identify other responsible parties.

LACK OF DEPARTMENT OVERSIGHT OF COUNTY GUARDIANSHIP SERVICES. The Department does not review county guardianships of at-risk adults to assess county compliance or practices, and Program management indicated that they do not think it is necessary to specify how counties should document their guardianship processes. Based on some of Program staff's comments regarding the problems we identified in the sampled cases, staff were unsure if the county's documentation met the requirements in rule and assumed that documentation from the courts was adequate.

Department QA reviews sample screened in cases that have been closed in each county each year to assess the screening process, assessments, delivery of services, and case closure, but Department management told us that the reviews specifically exclude county guardianships from the sampling. According to the Department, it does not review county guardianships because its reviews were designed to assess county compliance with rules for conducting and closing investigations, not to evaluate county activities related to the pursuit of guardianship. Staff at the 10 counties we interviewed reported that the QA reviews of screened in cases have helped them better understand and achieve compliance in investigations, which indicates that counties could benefit from further guidance provided through Department reviews of guardianship processes. Reviewing county processes for obtaining guardianships, either through existing case reviews or separate reviews, and verifying that counties document that they have met the requirements in statute and rule could help ensure that counties have consistent and compliant processes.

The Department needs to ensure that CAPS contains accurate start dates for guardianships to allow it to select cases for review. We found that CAPS does not always contain accurate start dates for county

guardianships. We identified three guardianships, including one in our sample, which had an incorrect start date recorded in CAPS. In the sampled case, a guardianship that began in 2018 was dated in CAPS as if it started in 2019; in the other two cases (outside our sample) CAPS showed start dates in Fiscal Year 2019 when they actually began in Fiscal Years 2012 and 2018 respectively.

WHY DO THESE PROBLEMS MATTER?

County guardianship is the most restrictive service that county adult protective services provides, and therefore the highest risk service, because, when a guardian is appointed, the courts remove the rights of at-risk adults to make fundamental decisions about their own lives—such as where they will live, what type of health care they will receive, their daily activities, and how they want to manage their finances—and place these rights in the hands of the county. Individuals for whom a guardian is appointed are vulnerable due to their incapacity to make decisions. The counties and Department have a responsibility to balance the protection of at-risk adults from mistreatment or self-neglect with the preservation of their rights to self-determination and should act with the utmost care and diligence when deciding to pursue guardianship. As such, both the county and the Department must ensure that the decision to petition the court for county guardianship of an at-risk adult is made based on the collection and consideration of relevant information about the adult's condition, the suitability of the county to serve as the guardian or conservator, and the other factors that are required in rule.

When counties do not have clear guidance or directives for documenting steps taken to petition for guardianships, and do not thoroughly document their processes, there is a risk that counties are not always adhering to statutes and rules that are intended to ensure county guardianship is only pursued as the least restrictive option and only when necessary to address the needs of the at-risk adult. Further, when the Department does not have processes in place to oversee county decisions about pursuing guardianship, it is not ensuring adherence to the requirements in statute and rule that are intended to protect the

rights of at-risk adults. Staff in the counties we interviewed told us that a county becoming an adult's guardian should be an option of last resort. When counties do not sufficiently document that they have followed all applicable requirements before petitioning the court for guardianship or when obtaining guardianship, it is not always clear that they have pursued other available options for serving the adult's needs.

RECOMMENDATION 6

The Department of Human Services (Department) should ensure that the counties administering the Adult Protective Services Program follow statute and rules related to petitioning for guardianship of an at-risk adult by:

A Implementing written guidance and training for counties on the documentation that must be maintained in the Colorado Adult Protective Services system (CAPS) to demonstrate that county decisions to petition for guardianship and processes for obtaining guardianship comply with statute and rules.

B Implementing Department reviews of county guardianships for adult protective services cases to ensure that counties maintain required documentation in CAPS.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department agrees that the current practice of using case notes and supporting documents in CAPS to serve as support for the need for guardianship can be improved. Therefore, the Department will implement written guidance and training for counties on documenting the county's decision making process in CAPS.

B AGREE. IMPLEMENTATION DATE: JUNE 2021.

The Department agrees to implement reviews of county guardianships for adult protective services cases to ensure that counties maintain required documentation in CAPS. The Administrative Review Division, through its Steering Committee, will collaborate with state Adult Protective Services Program Staff, as well as county department of human/social services adult protective staff to design the review process.