GOVERNOR'S OFFICE OF ELDERLY AFFAIRS

ELDERLY PROTECTIVE SERVICES

I. DEFINITION OF PROTECTIVE SERVICES

Protective Services are those activities intended to assist eligible adults aged 60 and over who are residing in the community and/or clients who reside in a facility where the abuse is alleged to be commited by someone not employed by the facility and who have been harmed or are at risk of harm due to abuse, neglect, exploitation, or extortion. Protective Services include but are not limited to: receiving and screening information on allegations of abuse, neglect, exploitation and/or extortion; conducting investigations and assessments of those allegations to determine if the situation and condition of the alleged victim warrants corrective or other action, stabilizing the situation, developing and implementing plans for preventive or corrective actions, referring to necessary on-going services and/or to case management, ensuring services are obtained, initiating and/or referring for necessary civil legal remedies; and as indicated, referring cases to law enforcement and/or the district attorney and cooperating in any court proceedings.

II. MISSION STATEMENT

The Governor's Office of Elderly Affairs, Elderly Protective Services is committed to preserving and protecting the rights of persons with disabilities and vulnerable adults aged 60 and over in need of assistance due to abuse, neglect, self-neglect and/or exploitation, hereafter referred to as "abuse."

In pursuit of this commitment and in accordance with the provisions of LA R.S. 14:403.2 and LA R.S. 15:1501-1511, Elderly Protective Services is committed to establishing systems to provide protection to individuals who are unable to independently provide for themselves or to manage their resources and who are harmed or threatened with harm through the action or inaction of themselves, those entrusted with their care, or other parties.

III. GOALS AND OBJECTIVES

The primary goal of the Governor's Office of Elderly Affairs' Division of Elderly Protective Services is to prevent, remedy, halt, or hinder abuse, neglect, exploitation, or extortion of individuals in need of services as defined in this regulation and consistent with the provisions of LA R.S. 14:403.2 and LA R.S. 15:1501-15:1511. In order to achieve this goal, Elderly Protective Services shall pursue the following objectives:

1. Establish a system of mandatory reporting, intake, classification, timely investigation and response to allegations of abuse, neglect, exploitation, and extortion;

2. Provide protective services to the individual while assuring the maximum possible

degree of self-determination and dignity;

3. Coordinate with other community service and health service providers, to arrange and facilitate the process toward developing individual and family capacities to promote safe and caring environments for individuals in need of protection;

4. Secure referral or admission to appropriate alternative living arrangements if all efforts to maintain the individual in his/her own home fail;

5. Assist individuals in need of protection to maintain the highest quality of life with the least possible restriction on the exercise of personal and civil rights; and to

6. Educate the general public, as well as private and public service agencies, regarding the Protective Services Agency and the requirements of LA R.S. 14:403.2 and LA R.S. 15:1501-1511.

IV. HISTORY AND STRUCTURE OF ELDERLY PROTECTIVE SERVICES

The Adult Protective Services Act was first passed in 1981. The Department of Health and Human Resources administered the Elderly Protective Services program from 1981 to 1987. In 1987, the program was transferred to newly created Department of Social Services, but funding was not provided and the program was inactive several years. In 1992 responsibility for the program was divided between the Governor's Office of Elderly Affairs for adults 60 and older and the Department of Health and Hospitals for adults 18-59 and emancipated minors. Elderly Protective Services began operation in 1993 followed by Adult Protective Services in 1994. In 2013, both agencies were combined to create Adult Protective Services for adults 18 and older.

In 2017 the programs were separated with Adult Protective Services remaining with LDH and Elderly Protective Services returned to the Governor's Office of Elderly Affairs. Elderly Protective Services consist of 9 regional offices, six regional supervisors, Intake division and one Program Manager.

1. **Community Investigations/Non-licensed**
   The Community Investigations/Non-licensed section is responsible for conducting investigations, assessing risk, determining capacity, and for arranging services to protect vulnerable adultss with disabilities age 18 and 59 from abuse, neglect, exploitation, or extortion who live in a non-licensed setting.

   This division also investigates cases where the client lives in a licensed facility but the alleged perpetrator is not an employee of the facility.

2. The Intake Section

The Intake Section screens and accepts reports of abuse, neglect, exploitation or extortion which are called in or otherwise reported to EPS and provides information and referral on cases which are not eligible. Information is recorded and cases are assigned and priority set for investigation by this Section.

The Facility Investigations Section at LDH is responsible for investigating reports which involve LDH facilities and the accused is employed by the facility.

This section's responsibilities also include developing and monitoring policy, training and certifying investigators, and reviewing investigations to ensure that policy and procedures are followed.

It also serves as the first line of appeal if a consumer or complainant is dissatisfied with the outcome of a facility investigation. Other responsibilities include training and technical support to other persons who have duties under the abuse/neglect policy, such as client rights officers and members of investigative review committees and to other divisions of the Agency.

V. COMMUNITY COORDINATION

Elderly Protective Service programs work with other agencies and community partners, including, but not limited to, courts and law enforcement agencies, mental and physical health providers, domestic violence and sexual assault programs, aging and disability networks, substance abuse service providers, and tribal entities, including tribal services and tribal or Bureau of Indian Affairs (BIA) law enforcement.

The goal of these intentional and specific collaborations is to provide comprehensive services to vulnerable adults in need of protection by building on the strengths, and compensating for the weaknesses of the service delivery system available in the community, and by avoiding cross-purposes. One method to enhance community collaboration is through the performance of the Regional Coordinating Council.

The Governor's Office of Elderly Affairs, Division of Elderly Protective Services convenes a quarterly Coordinating Council meeting in each LDH region. LA R.S 15:1507(E) states the Adult Protection Agency shall convene a regional level coordinating council composed of representatives of both public and private agencies providing services, with the objectives of identifying resources, increasing needed supportive services, avoiding duplication of effort, and assuring maximum community coordination of effort. More information about the Regional Coordinating Council is located in Chapter 18 of this policy and procedures manual.

VI. PRINCIPLES OF ELDERLY PROTECTIVE SERVICES

Elderly Protective Services is guided by the *National Adult Protective Services Association (NAPSA) Code of Ethics* and the Adult Protective Services Recommended Minimum Program Standards and practice guidelines. The *NAPSA APS Code of Ethics* states that the Elderly Protective Services program and staff promote safety, independence, and quality-of-life for older persons and persons with disabilities who are being mistreated or in danger of being mistreated, and who are unable to protect themselves. Every action taken by Elderly Protective Services must balance the duty to protect the safety of the vulnerable Elderly with the Elderly's right to self-determination and older persons and persons with disabilities who are victims of mistreatment should be treated with honesty, caring, and respect by following these core principles:

1. Adults have the right to be safe.
2. Adults retain all their civil and constitutional rights, i.e., the right to live their lives as they wish, manage their own finances, enter into contracts, marry, etc. unless a court adjudicates otherwise.
3. Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
4. Adults have the right to accept or refuse services.

The EPS program is guided by practice guidelines that emphasize the EPS Worker's need to:

1. Recognize that the interests of the elder are the first concern of any intervention.
2. Avoid imposing personal values on others.
3. Seek informed consent from the adult before providing services.
4. Respect the adult's right to keep personal information confidential.
5. Recognize client differences such as cultural, historical and personal values.
6. Honor the right of adult to receive information about their choices and options in a form or manner that they can understand.
7. To the best of the worker's ability, involve the adult as much as possible in developing the service plan.
8. Focus on case planning that maximizes the vulnerable adult's independence and choice to the extent possible based on the adult's capacity.
9. Use the least restrictive services first and community-based services rather than institutionally based services whenever possible.
10. Use family and informal support systems first as long as this is in the best interest of the adult.
11. Maintain clear and appropriate professional boundaries.

12. In the absence of an adult's expressed wishes, support casework actions that are in the adult's best interest.
13. Use substituted judgment in case planning when historical knowledge of the adult's values is available.
14. Do no harm. Inadequate or inappropriate intervention may be worse than no Intervention.

I. ABBREVIATIONS

AG - Attorney General

ADHC – Adult Day Health Care – medical and social care provided for elderly and disabled clients at a center or day facility as part of a Medicaid home and community-based services waiver

APS - Adult Protective Services - services provided to identify and eliminate abuse, neglect, exploitation and/or extortion of adults ages 18-59 with disabilities

A/N/E/E – Abuse, Neglect, Exploitation, Extortion

BHSF - Bureau of Health Services Financing - the agency within DHH which manages the state Medicaid Program

AAA – Area Agency on Aging – A public or nonprofit agency designated by the state to address the needs and concerns of all older persons at the regional and local levels.

HSD - LDH Human Service District

CCW – Community Choices Waiver - a waiver issued for services for the elderly and adults with disabilities

CEC- Coroner's Emergency Certificate – a temporary commitment signed by coroner or designee declaring someone to be a danger to themselves or others

DA - District Attorney

LHH – Louisiana Department of Health - the administrative department of the State of Louisiana which includes Adult Protective Services

DCFS - Department of Children & Family Services - The administrative department of the State of Louisiana which includes the Bureau of Licensing, the Office of Community Services and the Office of Family Security

EPS – Elderly Protective Services – services provided to indentify and eliminate abuse, neglect, exploitation and/or extortion of adults aged 60 and above

GOEA - Governor's Office of Elderly Affairs - the administrative department of the State of Louisiana which provides supportive services to persons over sixty years of age and includes Elderly Protective Services.

HSS – Health Standards Section, the section within BHSF responsible for licensing, certifying and regulating long term care and other health care services.

LT-PCS- A service, provided through Medicaid, designed to provide in home care and supports to the elderly and disabled living in their own homes.

LGSI-Louisiana Guardianship Services, Incorporated – the nonprofit agency that provides independent guardian services and money management services to the elderly and disabled clients

MOU - Memorandum of Understanding - a written agreement between two agencies which defines the interaction between those two agencies

NAPSA – National Adult Protective Services Association

NOW – New Opportunity Waiver. A waiver program though OCDD that is intended to provide specific, activity focused services rather than continuous custodial care.

OASDI - Old Age Survivors and Disability Insurance - Social Security insurance benefits paid in variable amounts to persons who have paid into the social security system during their working years, or their dependents

OBH – Office of Behavioral Health – The LDH office which provides services for person with mental illness/behavioral disorders and/or addictive disorders

OAAS - Office of Aging and Adult Services – the office within LDH which provides services to the elderly and disabled adults.

OCDD - Office for Citizens with Developmental Disabilities - the office within LDH that provides services for persons with developmental disabilities

OCS - Office of Community Services - an agency within DCFS which provides children's protective services

OFS - Office of Family Security - the office within DCFS which processes requests for food stamps and cash benefit programs

OPC - Order of Protective Custody - a judicial order awarding custody of one person to another person or entity

OPH – Office of Public Health

PEC – Physician's Emergency Commitment - a temporary commitment form signed by a physician declaring someone to be a danger to himself or others

SRI - Special Request Investigation

SSA - Social Security Administration - the agency of the federal government that provides disability benefits through OASDI or SSI, and medical benefits through Medicare or (in conjunction with the states) Medicaid

SSI - Supplemental Security Income - a monthly payment awarded to the elderly or adults with disabilities who do not qualify for OASDI or whose Social Security benefit is lower than the flat SSI benefit

THI/SCI –Traumatic Head Injury/Spinal Cord Injury Trust Fund

II. DEFINITIONS

Many of the following definitions are directly from the Louisiana Adult Protective Services ACT, LA R.S. 14:403.2, and LA. R.S. 15:1501-1511 and relate specifically to the provision of Adult and Elderly Protective Services.

ABANDONMENT - is the desertion or willful forsaking of an adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

ABUSE - means the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value.

ACCUSED - The person alleged to have abused, neglected, exploited, or extorted the adult.

ADULT - A person eighteen years of age or older or an emancipated minor who is mentally, physically, or developmentally disabled and whose disability substantially impairs the person's ability to provide adequately for his/her own care or protection.

ADULT PROTECTIVE SERVICES ACT - The statute enacted to provide for a system of protective services for certain vulnerable adults living in Louisiana. (See LA R.S. 14:403.2 and LA. R.S. 1501-1511 located in Appendix A).

ALLEGATION - A statement or assertion by a person, either oral ,written or email, of specific injury, harm or condition to an adult in which the reporter believes the adult has been or is threatened with being neglected, abused, exploited and/or extorted.

ADULT PROTECTIVE SERVICES - The agency located in the Office of Aging and Adult Services named as the policy setting and oversight agency for protective services for adults 18 years 59 years of age, and emancipated minors who are physically, mentally, or developmentally disabled and in need of protective services as provided in LA. R.S. 14:403.2 and LA. R. S. 1501-1511.

CAPACITY TO CONSENT - The ability to understand and appreciate the nature and consequences of making decisions concerning one's person, including but not limited to provisions for health or mental health care, food, shelter, clothing, safety, or financial affairs. This determination may be based on assessment or investigative findings, observation, or medical or behavioral health evaluations.

CAREGIVER - Any person or persons, either temporarily or permanently responsible for the care of an adult with disabilities. For the purpose of this policy; includes but is not limited to adult children, parents, relatives, neighbors, who have voluntarily assumed the care of a person with disabilities or have assumed the voluntary use or tutelage of a person with disabilities' assets, funds, or property.

COLLATERAL CONTACT - Any adult, other than a caregiver or the subject of the investigation, who may have information about a case being investigated. Examples may include family members, neighbors, witnesses, physicians, other medical personnel, law enforcement, and others.

COMMUNITY CHOICES WAIVER – A program of home and community based services provided to an adult with disabilities which enables them to remain in their own home with supportive services and avoid placement in an institutional setting.

COURT OF COMPETENT CIVIL JURISDICTION - The appropriate local area court which covers the jurisdiction where the adult resides.

CURATOR/CURATRIX - A person appointed by the court to manage the affairs and person for the interdict.

ELDER – A person sixty years of age or older whose disability substantiatlly impairs the person's ability to provide adequately for his/her own care or protections.

EMANCIPATED MINOR - A person under the age of 18 who administers his or her own affairs or who is relieved of the incapacities which normally attach to minority. Minors can be emancipated either by an act by a Notary Public, marriage, or judicial pronouncement.

EMOTIONAL ABUSE - The infliction of mental injury on an adult by other parties to such an extent that his/her health, self-determination or emotional well-being is endangered and which has the potential to require intervention of a clinical nature. Examples include but are not limited to harassment, cursing, degrading remarks, intimidation, ridicule, threatening to withdraw care, seclusion and restraints directed towards the adult.

EX PARTE ORDER - A judicial proceeding, order, injunction, etc., is said to be ex parte when it is taken for the benefit of one party only, and without notice to, or contestation by, any person adversely interested. The order is usually done in an expedited manner or presented to the court as an emergency.

EXPLOITATION - means the illegal or improper use or management of an elder's funds, assets, or property, or the use of an elder's power of attorney or guardianship for one's own profit or advantage

EXTORTION - is the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority.

GUARDIANSHIP - See Curator definition

INCIDENT REPORT - The information received by the Elderly Protective Services that an adult has been or may be abused and/or neglected. The information must include at least one allegation of harm to an adult as specified in LA R.S. 14:403.2 and LA R.S. 15:1501-1511.

INCOMPETENCY - A judicial finding based on satisfactory evidence of a person's inability to manage his/her affairs and/or person.

INJUNCTION - A court order which enjoins or restrains a party or parties from engaging in certain acts.

INTAKE - The process for:

1. Receiving and assessing reports/allegations.
2. Obtaining and recording essential and qualifying case data and information.
3. Determining acceptance/non-acceptance of case.
4. Properly referring those reports not accepted.
5. Classifying and prioritizing accepted cases.
6. Assigning case to an EPS Specialist.

INTAKE WORKER - The staff person who receives reports of allegations; obtains and records essential case data.

INTERDICTION - There are two types of interdiction

Full Interdiction - A judicial proceeding which authorizes a court, upon petition, to appoint a curator (guardian) for a person found to be incapable of managing his/her person or property because of mental deficiency, deviation, or physical infirmity.

Limited Interdiction (Partial) - An interdiction process whereby the court appoints a curator (guardian) and relieves the interdict of only those rights and responsibilities which the interdict cannot handle, i.e. medical, financial, placement, etc.

INVESTIGATION - The fact finding and assessment process whereby the Specialist obtains evidence and information, and makes observations in order to determine if the situation and condition of the adult warrant corrective or preventive action.

ISOLATION - includes:

1. Intentional acts committed for the purpose of preventing, and which do serve to prevent, an adult from having contact with family, friends or concerned persons. This shall not be construed to affect a legal restraining order.
2. Intentional acts committed to prevent an adult from receiving his mail or telephone calls.
3. Intentional acts of physical or chemical restraint of an adult committed for the purpose of preventing contact with visitors, friends, family or other concerned persons.
4. Intentional acts which restrict, place or confine an adult into a restricted area for the purposes of social deprivation or preventing contact with family, friends visitors or other concerned persons. However, medical isolation prescribed by a licensed physician caring for the adult shall not be included in this definition.

LAW - APS - See Adult Protective Services Act

LEGAL REPRESENTATIVE - See Curator/Curatrix

MEMORANDUM OF UNDERSTANDING - A written agreement between GOEA and another agency, to outline procedural matters and responsibilities between the two.

MONITORING – When EPS cases are closed but require periodic visits and reviews to assure compliance with EPS recommendations and services.

NEGLECT - means the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused.

PERPETRATOR - The person alleged to have abused, neglected, exploited, or extorted the adult.

PHYSICAL ABUSE - The injury, unreasonable confinement, intimidation or cruel punishment of an adult with resulting harm or pain.

POWER OF ATTORNEY - A legal instrument authorizing a person to act as attorney or agent of the grantor. It may authorize specific or general power. It may or may not involve fiduciary responsibilities.

PREPONDERANCE OF THE CREDIBLE EVIDENCE - Evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be provided is more probable than not.

REGIONAL COORDINATING COUNCIL - A regionally constituted committee composed of representatives of both public and private agencies which provide services to adults in need of protection. These Regional Coordinating Councils are designed to maximize resources available to adults in need of protection particular to that region by affecting a regionally individualized plan for the allocation or reallocation of available resources, expansion of programs, or redirection of current resource allocation.

REPORTER - The person who makes a report to EPS alleging abuse, neglect, exploitation, extortion, etc.

RESTRAINING ORDER - A judicial ruling that prohibits a person from having contact with or being in proximity to the alleged victim or from engaging in certain acts.

RISK ASSESSMENT - The factors considered by the EPS Specialist when determining the risk of harm to the adult. Known risk factors are assessed using the EPS Risk Assessment Matrix.

REVISED STATUTE LA R.S.14:403.2 - See Adult Protective Services Act.

REVISED STATUE LA R.S. 15:1501 – 1511. - See Adult Protective Services Act

SELF-NEGLECT - "Self-neglect" means the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected.

SERVICE PLAN - A plan developed to address the specific problem(s) or needs of an adult, or the actions or services needed to correct the problems, the persons responsible for these remedies and the time frames for completion.

SEXUAL ABUSE – means abuse of an adult, as defined in this Section, when any of the following occur:

(a) The adult is forced, threatened, or otherwise coerced by a person into sexual activity or contact.

(b) The adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact.

(c) The adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.

STABILIZED - A situation whereby prudent safeguards are implemented to offset the abusive and/or neglectful actions and/or where all reasonable steps have been taken to reduce the risk of harm.

TUTORSHIP, CONTINUING OR PERMANENT - A circumstance which occurs when the legal responsibility for an intellectually challenged child extends beyond that child's eighteenth birthday. Continuing tutorship must be granted to the tutor before the individual turns eighteen, and is usually granted to the parent or other person with custody of the child. The establishment of tutorship limits the individual's ability to contract or give medical consent among other things.

VICTIM - The elder alleged to have been abused, neglected, exploited, or extorted. (See definition of elder for further detail.)

III OPERATIONS

Elderly Protective Services operates within certain guidelines necessary for the efficient and adequate functioning of the agency. These operating guidelines may be adjusted by supervisory or administrative staff when it becomes necessary to do so. EPS Policies and Procedures are program requirements that all staff are responsible for knowing and following. Not following EPS policies and procedures may mean that staff members are not protected by the immunity from liability provisions of the EPS law. Persistent failure to follow policy and procedure will result in appropriate supervisory action.

I. COMPLAINTS AGAINST ELDERLY PROTECTIVE SERVICES

A. **Definitions**

For purposes of this policy the following definitions apply:

1. Complaint any allegation of wrongdoing or misconduct by EPS. Complaints may be submitted orally or in writing.

2. Misconduct - any action by an Elderly Protective Services Specialist which is considered detrimental to the welfare of a client, that is in violation of laws and regulations that govern the EPS Program, including Section 721 of the Older Americans Act, or the Adult Protective Services Act, LA R.S. 14:403.2 et seq., or LA R.S. 15:1501 – 1511.

B. **Procedure**

Any complaint or allegation of misconduct should be referred to the EPS Regional Supervisor who will notify EPS Program Manager of the complaint and, unless instructed otherwise, investigate the complaint. Following the Regional Supervisor's investigation, the findings are forwarded to the EPS Program Manager for review and disposition.

II. COMMUNICATIONS

Due to the emergent nature of Elderly Protective Services work, all staff members must make use of the communication methods available to keep information flowing between the field staff, supervisors and administration.

A. E-Mail

All Specialists must check and use e-mail (Outlook) when they first come into the office each day and regularly after that. Supervisors and Intake will use e-mail to contact

workers for non-emergency messages and for Priority 2 and Priority 3 case assignments in order to reduce the use of cell phones. Staff are expected to comply with the GOEA E-mail Policy.

B. Voice-Mail

Specialists are to make use of their voice mail to receive messages as well as to leave information for all callers about their whereabouts. Voice mail answering messages must be professional, must provide the toll free number to refer callers who want to report allegations of abuse, neglect, exploitation or extortion and to refer callers to your supervisor in the event the specialist is unavailable. The message must also instruct callers to hang up and dial 911 if there is an emergency.

Staff members are to check voice mail messages frequently. Staff must use the extended absence function to leave information about times when they will be out of the office for more than one day. Most of the voice mail systems have a function allowing the user to access them from outside the office which lets the staff member change the answering message and check messages while out of the office. Staff are to provide their supervisor with their voice-mail password to allow access to voice mail messages in emergencies.

C. Daily Schedules

Specialists must have a system for informing their supervisor and/or a designated person of their whereabouts while in the field as well as instances when they will be working after hours. On a daily basis, Specialists are to e-mail their supervisor with their schedule of field visits listing cases by case number, street addresses of private homes or names of well-known locations they plan to visit, the time they are departing the office, the time they will make their next appointment and an expected time of return to the office. These e-mails are to be copied to their supervisor's supervisor so that whereabouts will be available in two places for safety's sake. Staff members may also choose to post this information on their Outlook calendar. If this option is chosen, however, the staff member must give viewing rights for their calendar to their Supervisor and to the Program Manager.

D. 800 Number

The EPS toll free number is primarily for the public to make reports of abuse, neglect, exploitation or extortion. It may also be used by staff who need to contact the office. Staff members are to ask clients, family members or other contacts to call them at their office numbers or work cell numbers to avoid clients calling the EPS toll free number trying to reach staff.

IV. EQUIPMENT

A. Cell Phone

Specialists who are supplied with a cell phone and charger must comply with the GOEA Cellular Phone Policy. State-issued cell phones are to be kept turned on during agency hours and while conducting agency business and location must be enabled at all times. Personal calls, other than to notify your family if you are working late in the field, are prohibited.

B. Camera

Each specialist is supplied with a camera. This is to be used for the purposes of documenting evidence of abuse, neglect, exploitation or extortion while investigating cases. Photographs are to be stored using the "Instructions for Saving Digital Evidence" located the Forms Section of the policy manual. (This policy will be updated when the new EPSM system is operational and digital evidence can be uploaded into the specific client file.)

C. Computers

Each employee is supplied with a computer for work use. Computers are to be used for case related work including recording case data in the agency's data base, word processing tasks and, checking for work related information on the internet. All computer use must be in compliance with applicable GOEA Policy. To ensure access to case records and other data stored on computers when an employee is out of the office, each employee must keep his/her supervisor informed of any passwords needed to access agency information.

D. Tablet

VI. CASELOAD MAINTENANCE

A. Caseload Standard

The EPS recommended standard for caseload size is 50 cases or less for each EPS Speicalist. Specialist should manage caseload size by conducting timely and thorough investigations.

B. Office Time

Specialists are to manage their time so as to spend sufficient time each week in the office or home office to enter their weekly case documentation, make and return phone calls, staff cases and otherwise manage their case load. In the event that backlogs of written work or other case load issues develop, supervisors may require Specialists to set and observe scheduled office time. In such situations Specialists will be expected to observe the scheduled time except in emergency situations.

A. Case Entries

Cases shall be documented and entries made in the EPS database on an ongoing basis. Specialists are to document and save cases as they work, rather than have report writing

be a separate task to be completed after the case is finished. The format and scheduling of the entries and their content is discussed in the chapter on Documentation and in the Documentation Guide issued during training of new Specialists.

B. Staffing

Each Specialist is to complete a review of all open cases, returned cases and cases on monitoring status with their supervisor during each month. Time to discuss cases should be regularly scheduled each week and the Specialist should be prepared to discuss the status of each case assigned or worked during the previous week. Supervisors will establish a set time for the staffing to allow Specialists time to prepare and allow time for working on data files and/or reports. Supervisors should document this Staffing in the EPS database for each case discussed.

VII. FILE MANAGEMENT

File management is necessary to ensure the safety, security, and accessibility of all types of records as well as to define the proper procedure for destroying records. It is the responsibility of the regional supervisor to ensure that the cases are filed and destroyed according to policy.

A. File Storage

Active case records are maintained and secured by the specialist at all times. When storing files at home, they should be secured in a lockbox. Once the case is closed, it is filed alphabetically by fiscal year in a secure area designated for Protective Services files, within the regional office. Repeat cases are combined with the previous records. When that case is closed, it is filed alphabetically by the fiscal year in which the case was closed. Cases on monitoring status are filled separately by the regional supervisor. Once the case is removed from monitoring status, it may be filed with the closed case in the current fiscal year.

B. Photograph and Video (Digital Evidence) Retention

Digital images and records shall be stored in a centralized location and retained in accordance with the GOEA records retention schedule. This insures that confidential images and recordings collected as evidence in an EPS investigation are preserved for future use.

All digital images and recordings used as evidence in an Elderly Protective Services investigation shall be stored on the Specialist's laptop in a folder labeled "Digital Evidence" therein will contain additional folders labeled with the client case number.

(This policy will be updated when the new EPSM system is operational and digital evidence can be uploaded into the specific client file.)

C. Records Destruction

All records are retained according to the GOEA retention schedule. Approval for destruction of records is obtained by Protective Services Manager or designee from The Louisiana State Archives, a division of the Louisiana Secretary of State's office. A copy of the approval will be sent to the Regional Supervisors. The regional supervisor will send the EPS Manager or designee the dates of the records being destroyed beginning with the first and ending with the last record number.

VIII. TRAINING

A. Orientation

Specialists who are joining the staff of the Elderly Protective Services shall undergo a series of training sessions as orientation to the agency. Employees new to GOEA must attend GOEA orientation and complete additional required training, such as defensive driving. The initial training for the Elderly Protective Services introduces new employees to the agency's policies and procedures, basic principles of protective services, and critical incident investigation methods. Required training is noted on the form "Checklist for New EPS Specialists". Supervisors are responsible for ensuring that all items on this checklist are completed for new employees.

B. Inservice Training

Staff training meetings are scheduled on a regular basis to allow staff to learn about new and updated policies and procedures of the agency. Meetings will also include training on topics of interest to the Specialists that will help them perform their jobs more effectively. Attendance at these meetings is mandatory. In addition, the agency makes training available under other circumstances. On-line training is available for regularly scheduled topics such as driver training, as well as skill development in the use of computer software and other subjects. The state Comprehensive Public Training Program also makes classes available that cover skills necessary to public servants. Courses in supervision are mandatory for all supervisory staff in the Department.

All employees are also encouraged to attend professional development seminars on topics that are job related. For those offered by organizations outside the Department staff members may request conference leave and/or reimbursement which will be approved as time and budget allow.

IV. CONFIDENTIALITY

Information obtained as part of an investigation and/or contained in the case records of a case is confidential. It may not be released without written authorization from the client or the client's legal representative. However, certain information may be shared with law enforcement, with medical or social service agencies as needed to coordinate the provision of protective services to the client, and with regulatory agencies in the case of provider investigations. All EPS staff are expected to make every effort to maintain client confidentiality. When disclosures are required, only the minimum necessary information should be disclosed. Details of the confidentiality requirements are stated in the APS law.

Requests for written copies of information in an EPS record must be made in writing to the GOEA General Counsel. Specialists are to discuss with their supervisor any request for information prior to release. Subpoenas for case records shall be forwarded to GOEA General Counsel, who will respond as outlined below.

I. CONFIDENTIALITY REQUIREMENTS

A. HIPAA

The Health Insurance Portability and Accountability Act of 1996 places requirements on all entities that collect or process health information.

B. Release of Information

During the initial face-to-face contact with a client *who has capacity to consent* (or a client's legal representative), Specialists shall, whenever possible, obtain signed release of information forms naming all agencies or other entities from which it may be expected to need confidential client information. This will facilitate obtaining any information needed to conduct EPS business.

C. Pertinent Information

When it is necessary to share or obtain medical information, it should be limited only to the information pertinent to the particular situation. For example, HIPAA does not permit the release of a client's medical history to a social services agency unless it is necessary for that agency to provide a needed service. In such a situation it may be appropriate to release some but not all the information available to EPS. When there is any question about what information to release, a supervisor is to be consulted. Likewise, HIPAA does not permit a health provider to release a client's entire medical record to EPS. They may only release information pertinent to the case.

D. Other Sources

Similarly, some providers may refuse to release information to EPS without a signed release of information form. When such situations occur, providers should be advised that HIPAA permits disclosures to protective service agencies and that LA R.S. 15:1507 states that EPS shall have access to any records or documents necessary to the performance of our duties. Suggest consultation with the agency's HIPAA advisor (most large providers will have one). Again, refer all unresolved disputes to a supervisor.

E. Mandatory Documentation

HIPAA mandates that any medical information that is released must be documented indicating what information was released, when it was released, to whom it was released and for what purpose. This documentation should be entered with other case contacts on the Activity Tab of the record in the EPS database.

F. Mandatory Reporting

Reports to law enforcement required by state law are permitted by HIPAA. Reports shall contain information pertinent to the event being reported.

G. Internal Security

HIPAA requires that all client information be kept in secure places, free from public view or access. All EPS staff must have screen savers with passwords and ensure that electronic case files are not kept open when they have left their desks. When staff are not at their desks, paper case files must be stored in a locked filing cabinet, drawer or office.

Faxes or e-mails shall use incident numbers rather than names whenever possible. Documents that mention clients by name are to be labeled with the GOEA privacy and confidentiality warning. All agency fax cover forms contain the warning. The e-mail version follows:

> PRIVACY AND CONFIDENTIALITY WARNING
>
> This Email transmission may contain Protected Health Information, Individual Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/re-disclosure, copying, storing, distributing or the taking of action in reliance on the content of this Email transmission and any attachments thereto, is strictly prohibited. If you have received this Email transmission in error, please notify the sender immediately via telephone and destroy the contents of this Email transmission and its attachments.

Case numbers rather than client names are to be used on travel forms, overtime slips or similar documents.

H. Intake

Any person or provider who refuses to release information when making reports to EPS is to be advised that state law requires reporters to provide "the name and address of the adult, the name and address of the person responsible for the care of the adult, if available, and any other pertinent information". Since this is required by state law, it is a permitted disclosure under HIPAA. If the reporter works for a provider covered by HIPAA they should be referred to their supervisor or agency HIPAA advisor. All unresolved disputes are to be referred to a supervisor.

I. Subpoena for Records

If EPS is initiating a legal action, or if law enforcement is doing so, we may provide/release information in support of the action without a subpoena. However, when other parties subpoena records the following procedure shall be followed:

The employee receiving the subpoena shall immediately forward it and the requested record(s) to the or the Program Manager. The Director or the EPS Program Manager will send to GOEA General Counsel the subpoena, and a complete copy of the case record in the database to be redacted, and filed under seal with the appropriate Clerk of Court. This procedure is pursuant to LA R.S. 46:56 (H) (2).

J. Witness Statements

The following exception to the provisions of this chapter applies to written witness statements.

If a witness in an investigation requests a copy of his/her own statement, the Specialist should advise the witness that a copy may be made available at the completion of the investigation. In these cases, the investigation is considered complete when the supervisor has signed off on the case closure and/or final report. The witness' request may be made face to face (for example, at the time of the interview) or may be submitted in writing. Telephone requests are not acceptable. The request must be documented in the case activity log. The Specialist shall inform the supervisor of the request, and the supervisor shall review the statement to ensure it does not contain *information that reveals confidential information about the client(s) involved in the incident.* If there are no such concerns, the supervisor shall authorize the Specialist to release the statement. The authorization and release shall be documented in the case record. If there are concerns, the Supervisor shall contact the Program Manager for direction or consultation with EPS Legal.

II. Procedure for Release of Written Information from EPS Case Records

A. The Director of the Governor's Office of Elderly Affairs shall be considered the official custodian of information contained in EPS case records. Except as provided herein, no written information shall be released without the approval of the Program Manager or his/her designee.

B. In accordance with the APS Law (R.S. 15:1507 (I) (1)), information in case records other than the reporter's name may be shared with social service agencies, licensed health care providers, and appropriate state or local agencies as needed for the purpose of coordinating services or treatment to remedy abuse, neglect, exploitation or extortion of the client. In most circumstances, the sharing of information for these purposes is done verbally. No written information should be shared with such agencies without either written consent from the client or supervisory approval

C. Information, including the reporter's name, may be shared with law enforcement agencies that are pursuing criminal investigations related to the case. This information may be shared verbally or in writing, provided that referrals to district attorneys pursuant to LA R.S. 15:1507 (F) of the APS law shall be in writing. The EPS specialist shall document in the case record the date information was released, the name of the agency and individual with whom the information was shared, and what information was shared. **EXCEPTION**: Copies of medical records, including records of mental health or substance abuse treatment, shall not be shared without the consent of the client. Such records may be protected by federal regulations that prohibit release to anyone without consent.

D. The APS law also provides that information may be released upon written authorization from the adult or his/her legal representative. In situations where a client or his/her legal representative requests a copy of a case, the following procedure shall be followed:

1. Requests must be in writing and should be addressed to the GOEA General Counsel. If a written request is received which is addressed to someone else, it should be forwarded to the GOEA General Counsel for response.

2. Prior to releasing any written records, the EPS Program Manager or his/her designee shall verify:

    a. The identity of the person making the request;

    b. that the request is actually being initiated by the client or at the client's request;

    c. that any person claiming to be the legal representative of the client is duly authorized and provides valid written authorization to act as legal representative.

In order to verify this information, the EPS Program Manager or his/her designee may require that an EPS staff person interview the client to verify

the request, and/or that a request be notarized, and/or that appropriate proof of legal representation (e.g., representation agreement, letter of curatorship, etc.) be provided.

3. This information and any information obtained by EPS staff verifying the request is forwarded to GOEA General Counsel. GOEA General Counsel also accesses the EPS file and in consultation with the EPS Program Manager or their designee, determines what information is to be released.

4. As provided by law, prior to release, the report(s) shall be edited to protect the confidentiality of information relating to the identity of the reporter and to protect any other individual whose safety or welfare may be endangered by disclosure.

V. SAFETY

Specialists with Elderly Protective Services investigate situations that may present physical or environmental danger to both themselves and the clients which they seek to assess and protect. The Agency's intention is to prevent harm, in every manner possible, to our staff as well as our clients. The safety procedures outlined below are in place to minimize the danger to employees and clients.

I. SAFETY PROGRAM COMPONENTS

A. Intake Safety Checklist

As part of the intake process, reporters of allegations of A/N/E/E are asked about potential risk situations. The intake worker asks about behaviors or conditions on the part of the client or accused which may endanger the Specialist investigating the situations. There are also questions about the living situation and neighborhood which may require special precautions during the investigation. Questions about safety situations shall include but not be limited to: contagious disease, pets, household members with a history of violence, behavioral health or substance abuse issues, and structural hazards such as weak floorboards, obstructed entrances or unsound stairwells. Each Specialist shall review these comments attached to the intake report and make allowances for any problems which may arise. When there are any safety concerns, request law enforcement assistance during an initial visit or for follow-up visits.

B. Whereabouts

Each Specialist shall report their whereabouts on a daily basis, giving street addresses, locations and any possible unsafe situations to their supervisor or other administrative staff. Likewise, supervisors are to be notified of any visits that will extend beyond normal working hours as soon as possible, but by the end of the working day.

Specialists are to email their routine schedules to their supervisor with a copy to the EPS Program Manager. Unexpected visits after hours are reported to the Regional Supervisor.

If warranted, the Specialist asks for someone to accompany them to a visit, meeting them at a safe public place. Routes to the meeting place and the client's home are to be mapped out ahead of time. Specialists are to dress professionally and conservatively to fit the occasion and surroundings, wearing clothing which will allow quick movement in an emergency.

C. Safety During the Home Visit

Specialists are to be aware of others in the household, where exits are, and are to stay near an exit during the visit.

Specialists are not to involve themselves in domestic arguments, but are to remain aware of any developing situations which might threaten the client. A worker who becomes uncomfortable regarding their safety, e.g. weapons or drug use within view, should end the interview. Afterwards, from a safe environment contact the EPS supervisor to discuss the situation. It may be necessary to contact law enforcement for an escort to safely complete the interview or to report criminal activity.

D. Safeguarding Equipment & Valuables

Items like cell phones, laptop computers, cameras, personal valuables, etc. should be kept with the Specialist or in the trunk or other lockable space in the vehicle. Case files are not to be carried in vehicles except for those being worked on that day. Due to privacy and confidentiality concerns, files taken out of the office should contain as little confidential information as possible. For example, medical records, financial records, or witness statements taken earlier in the investigation, should be kept in the office. Relevant portions of a record needed for discussion with a witness or a collateral contact should be copied, leaving the original in the office.

E. Risk Management

During the course of an investigation or while providing or arranging services for clients, Specialists have an obligation to not only protect the client, but also to minimize any risk to the agency. Consent forms are to be used whenever possible to obtain information about a client's medical history or other situation.

On those occasions when it becomes necessary to provide transportation to a client in either a state owned vehicle or a Specialist's personal vehicle a Hold Harmless Agreement form shall be completed and signed by the client or responsible person. Specialists are not to operate their personal vehicles without the required liability insurance or without completing GOEA mandated driver training.

Specialists in Elderly Protective Services perform investigations that may take them into hostile and dangerous situations. Whereas Specialists are not authorized to carry firearms or other weapons in order to defend themselves in the event of physical attack, the Agency has adopted policy on the use of non-lethal force for the purpose of protecting the employee and is only to be used when their health and safety is threatened with imminent physical injury or harm.

While in the performance of their duties, Specialists shall make every attempt to avoid situations where an incident escalates to the point of physical attack. Such methods as verbal prompts and warning, as well as vacating the premises to secure assistance from law enforcement shall be employed prior to the use of any type force.

F. Incident Reporting Policy

All on the job incidents involving an EPS staff member where he/she is harmed, threatened with harm, required to use evasive action, or to request assistance from law enforcement to respond to a threatening situation shall be reported to the EPS Program Manager or designee within 24 hours of the time that the incident occurred. The EPS Incident Reporting Form is used for this report.

This form is not intended for use in routine situations where law enforcement is called because of potential dangers reported on the intake form such as unsafe neighborhoods, etc. It is for situations where there has been a serious threat to worker safety requiring an out of the ordinary response. Documenting such incident reports and reporting them to EPS state office is necessary for liability and risk management purposes.

II. INFECTION CONTROL

Infectious diseases are frequently the major problem of clients needing our services. Each Specialist is responsible for infection control and should be on the lookout for signs of possible infection. Specialists should use universal precautions whenever they come into contact with signs or symptoms of contagious diseases.

A. Universal Precautions

This term refers to barrier precautions used by employees to prevent direct skin or mucous membrane contact with blood or other bodily fluids that are visibly contaminated with blood. These precautions should be applied to the blood and body fluids of ALL persons. This is what is meant by universal. The purpose of universal precautions is to protect individuals from HIV, all forms of hepatitis and other communicable diseases. *Frequent hand-washing is the most important infection control measure.* Washing your hands before and after contact is the single most important way to prevent the spread of infections.

B. Guidelines on the Use of Infection Control Supplies

EPS Specialists should not provide direct care or emergency medical services. In cases where such services are needed, specialists shall call 911 for assistance. However, there are situations where specialists may have direct contact with clients or conditions that carry a risk of infection. Infection control supplies may be ordered through GOEA. In conjunction with hand washing, wearing gloves can decrease the spread of infection by 90-95%.

1. **Infection Control Guidelines** instruct *direct care workers* to wear gloves when:
    a. changing diapers;
    b. cleaning bathroom facilities;
    c. changing dressings;
    d. handling clothes contaminated with bodily fluids;

e. bathing clients who have wounds or lesions;
f. if worker has any open cut on hands;
g. cleaning trash cans;
h. performing any invasive procedure, cleaning trachs, changing tracheostomy or gastrostomy tubes, suctioning mouth, nose, etc. (in these case *sterile* gloves are required).

EPS SPECIALISTS WILL NOT BE PERFORMING THESE TASKS.

2. **Gloves** - are to be worn if a client, accused or other person in a household where an investigation is being conducted has a disease which can be transmitted by direct contact, *and hand contact with potentially infectious persons or materials can reasonably be anticipated*. Gloves may also be worn in such situations when the Specialist expects to be handling or touching contaminated items or surfaces (e.g., physically examining an infected client to check for bruising).

3. **Masks** - are used in direct care settings whenever splashes or sprays (e.g., sneezing, coughing) may generate droplets of infectious materials. Masks may not provide protection from some airborne infectious agents. Specialists may choose to wear a mask if a person who needs to be interviewed is coughing or sneezing heavily. However, Specialists are expected to use common sense and to consider the need to build rapport with clients in order to conduct an effective interview.

4. **Gowns -** are worn in direct care settings whenever potential exposure to the body is anticipated, such as in lifting, bathing, etc. of clients. There should be few, if any, situations where such protective measures are necessary for Specialists. Specialists who encounter a situation where a gown is needed shall consult with a supervisor and/or a program manager.

5. **Preventive Measures -** Another important form of infection control is using preventive measures. Specialists are encouraged to obtain and stay up-to-date on vaccinations for common diseases. This would include immunizations such as tetanus shots, flu shots, etc. Vaccinations are also available for diseases such as hepatitis A and B, pneumococcus, mumps, measles and rubella, diphtheria and tetanus, and influenza. Specialists are also encouraged to obtain periodic tests for TB or any other disease to which they have reason to believe they have been exposed. Immunizations may be covered by health insurance or offered by the parish health unit

III. TRAINING

Newly hired EPS Specialists will receive orientation and comprehensive training that includes safety. The new EPS Specialists learn how to prepare for safety concerns before leaving the office; how to observe and prepare for safety concerns upon arriving at the interview location; AND how to observe and prepare for safety issues once on the property and in the house.

VI. ELIGIBILITY FOR ELDERLY PROTECTIVE SERVICES

Basic eligibility criteria for elderly protective services are derived from the APS law. The law protects persons who:

1. Are age 60 or over;

2. Due to a physical, mental, or developmental disability or the infirmities of aging, is unable to manage their own resources, carry out the activities of daily living, or protect themself from abuse, neglect, and exploitation;

3. Is alleged to have been abused/neglected/exploited or extorted as defined herein.

There are no financial eligibility criteria for Elderly Protective Services.

I. ELIGIBILITY CRITERIA

In order to be accepted for investigation, the eligible person must be a resident of Louisiana or the alleged abuse must have occurred in Louisiana. Cases where a person may reside in one state and is alleged to have been abused in another will be coordinated with the adult protective services program in the other state.

GOEA is the designated protective services agency for persons who meet the criteria listed above.

The APS law allows the Secretary of LDH to assign responsibility for investigating abuse involving persons residing in facilities or receiving services regulated by LDH to various sections of the Department. As specified in the APS Administrative Rule, investigations by the EPS program are generally limited to cases involving adults who reside in non-licensed community settings and/or cases where the accused is not a staff person of a licensed provider. Exceptions to this may be made where EPS has an inter-agency agreement or Memorandum of Understanding with a licensing or certification agency that provides for EPS to investigate. Such exceptions are discussed in more detail in Chapter Seven, Intake and in Chapter Ten, Special Investigations.

The criteria for acceptance of a case for investigation are presented in a matrix format and discussed in detail below.

II. EPS ELIGIBILITY CRITERIA MATRIX

In order to be eligible for EPS services an adult must meet the criteria outlined in the checklist.

Criterion	Yes	No	Comments
1. Adult is alleged to have been harmed or to be threatened with harm as a result of abuse, neglect, exploitation, or extortion (A/N/E/E)			If yes, go to number 2. If no, ineligible. SEE INSTRUCTIONS FOR GUIDELINES IN MAKING THIS DETERMINATION.
2. Age 60 or over			If yes, go to number 3. If no, ineligible. Make appropriate referrals when needed.
3. Physical, mental, or developmental disability or infirm due to age			If yes, go to number 4. If no, ineligible.
4. Unable to manage own resources.			If yes, eligible. If no, go to number 5. SEE INSTRUCTIONS AND GUIDELINES FOR HELP IN MAKING THIS DETERMINATION.
5. Unable to carry out the activities of daily living.			If yes, go to number 6. If no, and answer to number 4 is also no, ineligible. SEE INSTRUCTIONS AND GUIDELINES FOR HELP IN MAKING THIS DETERMINATION.
6. Unable to or protect himself from abuse, neglect, or exploitation.			If yes, go to number 6. If no, and answer to number 4 is also no, ineligible. SEE INSTRUCTIONS AND GUIDELINES FOR HELP IN MAKING THIS DETERMINATION.
7. A/N/E/E allegedly occurred in unlicensed community setting.			If yes, eligible. If no, go to number 7 for exceptions
8 A. A/N/E/E allegedly occurred in a licensed facility or program – which includes			A. If accused is private provider/program staff, refer to appropriate licensing agency. If accused is someone other

- Adult Residential Care (board & care), Day programs, respite, etc., and the alleged victim is NOT a home and community based services recipient. . .			than staff (i.e., family, neighbor, etc.) accept and notify licensing agency. If questions about a specific case, refer to EPS Manager (or designee) for approval. SEE INSTRUCTIONS.
B. A/N/E/E allegedly occurred in a licensed facility or program - includes Supervised Independent Living (SIL), PCA, etc., and the alleged victim IS a home and community based services recipient. . .			B. Reject and refer to appropriate licensing agency.
C. Accused is staff of LDH program.			C. . Reject and refer to appropriate Investigative Unit.
D. Alleged victim resides in, or abuse occurred in, a licensed setting but adult is reported to be in *imminent danger.*			D. Reject and notify licensing agency and Law enforcement.
E. Alleged victim resides in licensed setting but A/N/E/E occurred while outside facility and/or accused is not provider staff.			E. Eligible provided other criteria are met.

ELIGIBILITY MATRIX - INSTRUCTIONS AND GUIDELINES

A. General Eligibility

In order to be eligible for EPS services under LA R.S. 15:1501-15:1511, the adult must meet criterion 1, criterion 2 , criterion 3, *either criterion* 4 or 5, and criterion 6 (or one of the exceptions in criterion 7). This means a **yes** answer to items 1, 2, and 3, a **yes** answer to at least one of items 4 or 5, and a **yes** answer to 6 (or 7).

1. Harmed or Threatened with Harm as a Result of A/N/E/E - The APS law defines the following:

Abuse: means the infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value.

Sexual Abuse: means abuse of an adult, as defined in this Section, when any of the following occur:

(a) The adult is forced, threatened, or otherwise coerced by a person into sexual activity or contact.

(b) The adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact.

(c) The adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.

Neglect : means the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused.

Self Neglect: "Self-neglect" means the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected.

Exploitation: means the illegal or improper use or management of an adult's funds, assets, or property, or the use of power of attorney or guardianship for one's own profit or advantage

Extortion: is the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority.

The APS law requires reports to be made by any person "having cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by A/N/E/E." The terms "has been" and "may be" imply that the A/N/E/E may have occurred in the past or may reasonably be expected to occur in the future. Therefore, a case should not be rejected simply because the adult has been *temporarily* removed from an abusive or neglectful situation and is currently not at-risk. There may not be enough information available at intake to determine the future risk to the adult. This is best done during the investigation, the purpose of which, as stated in the law, is "to determine if the situation and condition of the adult warrant further action."

The terms "have been or may be further adversely affected" and "are harmed or threatened with harm" should be considered to effectively mean the same thing.

"Threatened with harm" need not be limited to verbal threats. Rather the term should be taken to mean the same thing as "may be further adversely affected". That is, the adult is in or is likely to be returned to a situation where he/she is *at risk* from A/N/E/E. Stated another way, the adult is in or likely to be returned to a situation where there is cause to believe that A/N/E/E may occur unless protective services are provided.

Reports of A/N/E/E incidents that occurred more than one year prior to the date the report was received need not be accepted for investigation. An exception is a report which includes an allegation of sexual abuse involving An adult who is physically or mentally incapable of resistance or who lacks the mental capacity to consent or to understand the nature of the act (e.g., victim is severely mentally retarded, victim is brain damaged from head injury). If the report is not accepted due to the time limit, the reporter will be advised that the A/N/E/E may constitute a criminal violation and that the past incident or behavior should be reported to law enforcement.

2. Age – self-explanatory. Allegations of abuse involving persons under age 18 (unless an emancipated minor) will be referred to the Child Protection Service agency. Allegations of abuse involving persons aged 18-59 will be referred to the Adult Protection Service Agency.

3. Physical, Mental, or Developmental Disability or the Infirmities of Aging - Since no specific definition for this term is provided in the APS law, individuals who have received or appear to be in need of behavioral health, substance abuse, or developmental disabilities services will be considered eligible provided they meet the other criteria. Likewise, anyone with a physical disability who meets the remaining criteria will be considered eligible. There is no need for "ranking" or determining "level" of disability in order to meet this criterion. The degree of impairment is determined through the answers to criteria 4 and 5. A reporter's description of the alleged victim's disability or dysfunction is accepted at intake. Generally, anyone who is receiving SSI, Social Security Disability, OCDD services, or other services for which disability is an eligibility requirement should be considered to meet this criterion for intake purposes. For further discussion refer to EPS Policy Guidelines on Definition of Persons with Disabilities.

4. Disability Substantially Impairs Ability to Adequately Provide for Own Care - A yes answer to this question means that, based on the information provided by the reporter, the alleged victim's disability renders him/her unable to manage his own resources, carry out the activities of daily living, or protect himself from abuse, neglect, or exploitation. This may include handling money, paying bills, protecting property, securing medical and/or social services, and maintaining a safe and healthy living environment. It would also include the inability to provide for one's activities of daily living which are essential to self-care (such as bathing, feeding oneself, dressing, toileting, transferring from bed to chair, walking, etc.) and activities which reflect one's ability to

perform household tasks or to meet needs within the community (such as shopping, cooking, cleaning, getting around in the community, using the telephone, managing money, managing medications, etc.). The adult is eligible if unable to fulfill any of these tasks without assistance due to disability, provided the other key criteria are met. For further discussion refer to EPS Policy Guidelines on Definition of Persons with Disabilities.

5. Disability Substantially Impairs Ability to Adequately Protect Oneself from Abuse, Neglect, Exploitation, etc. - The basic premise behind adult protection laws is that any disability which substantially limits one's ability to care for one's self or manage one's resources makes one *vulnerable* to A/N/E/E. Impaired intellectual functioning, as typically associated with an intellectual disability or severe behavior disorder or substance abuse can make one vulnerable due to impaired ability to understand right from wrong, to conceptualize and implement avoidance or defensive action, or due to feeling of dependency, vulnerability, helplessness, etc. Significant sensory or communication deficits (blindness, deafness, inability to speak) or physical conditions involving impaired mobility would interfere with a person's ability to respond to danger or threats. A medical condition requiring the use of special equipment or facilities can cause an adult to be subject to A/N/E/E by whoever can control access to these necessities. A key issue in answering this question is therefore, the degree to which the adult is *dependent* on others for meeting these basic needs. The greater the adult's degree of dependence, the greater is his/her potential vulnerability to A/N/E/E. For further discussion refer to APS Policy Guidelines on Definition of Persons with Disabilities.

6. Living in Unlicensed Community Setting - With the exceptions noted in number 7 on the chart, reports involving residents of licensed facilities will be referred to the designated investigative entity, (i.e., APS-Residential Program for state operated 24 hour mental health hospitals, developmental centers and groups homes, and ADA inpatient units) and/or to the appropriate licensing agency. LDH/Health Standards is the licensing agency for private Adult Residential Care, Day Programs, mental health group homes, nursing homes, private ICF/MRs (MR group homes), ADA halfway houses, private hospitals, etc.

7. Exceptions - Reports accepted pursuant to an exception are coordinated with the appropriate licensing agency. Licensing agencies should be notified of any case we accept involving An adult in a licensed facility. If the accused is someone other than staff (i.e., family, neighbor, etc.), then EPS accepts, and notifies the appropriate licensing agency. If the accused is staff of a LDH program, EPS rejects the report and refers the investigation to the appropriate investigative unit.

If the adult lives in an unlicensed setting but the accused works for a licensed provider and the adult is NOT a home and community based services recipient, the report should

be referred to the licensing agency. Reports involving facilities or programs licensed by DCFS will be referred to DCFS. Reports involving home and community based services recipients who are mistreated by providers who are employees of licensed agencies, e.g., home and community based services recipients living in Supervised Independent Living who are abused or exploited by PCA providers, are referred to Health Standards Section of LDH. If there is a question about whether a case should be accepted or referred, consult the EPS Director or designee.

B. Special Cases

1. Spousal abuse is not considered an EPS issue *unless* the abused spouse has a disability, in which case reports will be accepted provided the other criteria are met. Reports of spousal abuse where the abused spouse is not disabled are referred to local law enforcement and/or battered women's programs.

2. Homeless individuals are not eligible for EPS solely by virtue of their lack of shelter. If, however, a homeless person has a disability, is substantially impaired and threatened with harm due to A/N/E/E, he/she would be eligible. Reports that imply self-neglect, i.e. individual is dirty, smelly, unkempt exhibiting socially unacceptable, strange or bizarre behaviors *that are associated with any mental or physical disability* shall be accepted if other criteria are met. Additionally, information provided must contain identifiable details that will allow the specialist to recognize the adult upon sight even when the name of the adult is unknown. Homeless persons who are not eligible will be referred to local shelters and Law enforcement may be contacted for a welfare check.

3. Repeat cases will be handled in accordance with the APS Repeat Case Protocol, as discussed in Chapter VII, Intake.

4.Special requests from a licensing agency not covered by an interagency agreement for EPS to investigate a report of A/N/E/E are referred to the EPS Manager or designee for a determination. (In absence of the Manager, designees are EPS Program Managers and Intake Supervisor).

5.Financial Exploitation cases involving scams will only be accepted in situations where there is concern that the adult does not have the cognitive abiltity to understand the nature of scams. All other reports of scams will be referred to the appropriate Law enforcement agency. In addition a report will be made to the FBI watchlist.

III. DEFINITION OF "PERSON WITH DISABILITIES"

EPS has accepted the following as the definition of a person with disabilities: a person who due to a mental, physical, or developmental disability or infirmities of aging is unable to manage his own resources, carry out the activities of daily living, or protect himself from abuse, neglect or exploitation.

This definition establishes two criteria that must be met for a person to be considered disabled for EPS purposes. First, the person must have a mental, physical, or developmental disability or infirmities of aging. Second, the disability or infirmity must substantially limit the person's ability to manage resources, carry out the activities of daily living or protect himself from abuse, neglect or exploitation. In assessing whether a person reported to EPS appears to meet this definition, the specialist must consider the degree of impairment and how these factors affect the person's vulnerability to abuse, neglect, or exploitation.

A. DISABILITY

First, the specialist must decide whether the person has a physical, mental, or developmental disability, etc. Examples include, but are not limited to:

1. intellectual disability
2. autism
3. epilepsy
4. visual, hearing, or mobility impairments
5. behavioral illness
6. congestive heart failure
7. emphysema
8. multiple sclerosis
9. Alzheimer's disease or a related disorder
10. Ccystic fibrosis
11. Alcoholism/drug addiction

B. CAUSALITY

If the person has a disability, then the specialist must determine whether the individual's inability to protect or take care of self is due to the disability. To do this, the specialist first considers whether the disability causes the person to require assistance in **one or more** of the following:

1. mobility
2. bathing

3. toileting
4. grooming
5. dressing
6. meal preparation
7. feeding
8. housecleaning
9. taking medication
10. grocery shopping
11. money management

A person who is unable to perform one or more of these tasks without assistance is considered unable to provide his/her own care. Two other situations might exist where the individual, though able to provide for his/her own care, may not be able to provide for his/her own protection.

First, the person may, as a result of the disability, be unable to make a voluntary choice due to coercion by others or internal pressures that diminish freedoms.
For example, a mildly intellectually disabled individual might be able to more or less perform activities of daily living, but might not have a sufficient understanding of appropriate sexual behavior to give informed consent to sexual activity. Such a person would be considered unable to provide for his/her on protection and therefore meet the definition of a person with a disability.

Similarly, a person who can perform activities of daily living may, due to a disability such as behavioral illness or substance abuse, be unable to exercise choices or freedoms. For example, a person with a behavioral illness who is living with someone who financially exploits or emotionally or physically abuses them may, due to their behavioral illness, not have the skills or the self-confidence to seek an alternative living arrangement, make a report to the police, etc. Such a person would be considered unable to provide for his/her on protection and therefore meet the definition of a person with a disability.

Finally, a person may, as a result of disability, be unable or unwilling to recognize and remedy serious threats to personal well-being. An example of this situation is the adult with a behavioral illness who is not taking medication and engaging in behavior which poses a threat to safety or well-being.

After considering the above factors, the specialist makes a professional judgment as to whether the individual meets the definition of "person with disabilities, that is, whether the person's disability keeps him from being able to protect himself from abuse, neglect, or exploitation. **WHEN IN DOUBT THE SPECIALIST SHOULD ERR ON THE SIDE OF CAUTION AND CONSIDER THE PERSON ELIGIBLE.**

As an example, a reporter may provide information indicating that a person is depressed. The person would appear to have a substantial impairment if he or she is experiencing problems related to the depression, which might include one or all of the following:

1. not eating properly
2. experiencing sleep disturbances
3. neglecting personal hygiene or care of their home
4. having problems with financial management
5. refusing needed medical or psychiatric care.

Similarly, the report may indicate that the person has a back problem.

6. If the individual is able to perform activities of daily living and does not appear to be a substantially impaired, he or she would not meet the definition of "person with disabilities".
7. If, on the other hand, the back problem substantially limits his mobility and his ability to perform activities of daily living and/or protect himself from abuse, neglect, or exploitation, he or she would meet the definition of disabled person.

In addition to the above, the specialist must determine whether impairment results in neglect of a strictly financial nature.

If the **only** problem is an impairment which restricts the person from providing food, shelter, medical care, etc. for himself because of an inability to work, the individual is not considered substantially impaired. For example, if the person cannot work because of a broken arm, heart condition, or back problem, but does not have a significant impairment in the performance of activities of daily living, the impairment is not considered substantial. These individuals should be referred to other community resources.

Two other factors must be considered in making a final determination.

If a person has been declared by a court of law to be incapacitated, then they would be considered substantially disabled.

If a person has qualified (or is likely to qualify) for services from a program or agency, such as OCDD, which requires a substantial disability for eligibility, they should be considered to automatically meet the definition of a person with disabilities, as should persons receiving SSI, Social Security Disability, or Veteran's disability benefits.

VII. INTAKE

The intake process includes the following activities: receiving, gathering information about, and evaluating reports of abuse, neglect, exploitation, and/or extortion; accepting, prioritizing, and assigning reports accepted for investigation; referring reports not accepted for investigation to appropriate agencies or resources; entering all reports (accepted and rejected) into the incident tracking database and providing copies of certain reports to law enforcement as required by law.

I. REQUIRED TRAINING FOR INTAKE WORKERS

All Intake staff (including Supervisors) must be trained in EPS Intake Standards by EPS staff, or have had equivalent training and/or experience, as deemed by the Program Manager. This training will include but not be limited to:

A. Telephone techniques
B. Program eligibility,
C. Entering information into the EPS database,
D. How to handle cases which are not accepted for investigation.

II. GENERAL INFORMATION FOR REPORTERS

The APS law provides the following with respect to any person who contacts the Intake Unit to report allegations of abuse, neglect, exploitation or extortion:

> Reporting suspected abuse, neglect, exploitation or extortion of adults with disabilities is required by law.
>
> The reporter's identity (if given) is not disclosed except to law enforcement or the courts, as required by law. If reporters are reluctant to reveal their identity, EPS accepts anonymous reports.
>
> The reporter is immune from civil/criminal liability when making a report in good faith and cooperating in the investigation of the report.

Callers shall be informed of these provisions as the circumstances require, e.g. when a caller is reluctant to give a name, expresses concern about liability, etc.

III. ACCEPTING OR REJECTING A REPORT

A. Eligibility for Services

In order for a report to be accepted for an EPS investigation, the adult must meet the eligibility criteria as outlined in the APS Law. These criteria are presented in a matrix format and discussed in detail the EPS Eligibility Matrix, which is included in Chapter VI, Eligibility.

B. Ineligibility/Rejected

If the adult does not meet the eligibility criteria for EPS services, the Intake Specialist shall:

1. Advise the caller of the reason the report is not accepted.

2. Refer to law enforcement if appropriate.

3. If the call involves a report of abuse not investigated by EPS, refer to the appropriate agency for investigation. If the reporter is An adult or other person who may need assistance or have difficulty contacting the other agency, the Intake Specialist shall take the information and make the referral directly or connect the reporter to the other agency by phone. If the call does not involve a report of abuse, refer the caller to other service agencies or program offices as appropriate.

4. If the adult is deceased prior to the time the report is made, refer to the standards in the chapter on closure to determine if an investigation is necessary.

5. Enter the call as a reject into the incident tracking database.

6. Send an email to the Intake Supervisor to include the case number and the reason for rejection for final review, if approved the Intake Supervisor will document the review for rejection in the case activity log ensuring the appropriateness of the rejection and approapriate referral.

IV. INTAKE PROCEDURES

A. When a call is received, the intake Specialist identifies EPS and his/her name.

B. The intake Specialist interviews the reporter and gathers sufficient information to determine whether the case meets eligibility criteria as described in Chapter VI, Eligibility.

C. If the adult is not eligible for services, the intake worker handles the call as described above.

D. Cases accepted for investigation are opened in the name of the adult who is the subject of the report.

E. When the reporter states the adult lives in a group, board and care, other residential facility, the intake worker must determine if the home is licensed by HSS (ICF/MRs and Adult Residential Care facilities).

1. HSS should be contacted directly to determine licensure.
2. When licensed, the report is referred to HSS and entered as a rejected case in the database.
3. When unlicensed, the case is accepted and intake procedures proceed as outlined below.

F. As soon as sufficient information is obtained to make an eligibility determination, the pertinent information is recorded in the incident tracking database. The case number is then e-mailed to the Intake Supervisor on duty for review. The intake Specialist shall not delay giving the case to the supervisor while attempting to obtain demographic or other information not directly required in determining eligibility.

G. The Intake Supervisor reviews and makes a final determination whether to accept the case for investigation. When accepted, the Intake Supervisor or Intake Specialist classifies the case as to type(s) of abuse and priority level and assigns the case to an EPS Specialist. Priority one cases are assigned as soon as possible (on the same day of receipt, if at all possible). Where immediate intervention is needed, priority one cases shall be assigned prior to completion of all data entry on the case. When assigning Priority one cases the Intake Unit contacts the EPS Specialist immediately by telephone or cellphone in order to facilitate rapid contact. Priority two and priority three cases are assigned either the same day or as early as possible on the next working day. Assignments of priority two and priority three cases are sent via email and may be left on the Specialist's voice mail.

H. The intake Specialist completes gathering information then enters the case classification, priority, and assignment information into the incident tracking database. If the adult has had a previous case, the intake Specialist also enters the previous case number in the description section of the database.

I. The intake Specialist emails the case number to the EPS Specialist and their Supervisor and faxes or emails any other relevant information collected at intake. All documentation taken by the Intake Specialists (for all cases) is maintained in an intake folder, by month of report. Cases involving allegations of physical or

sexual abuse shall also be faxed to the sheriff in the parish where the incident occurred (i.e., the New Orleans Police Department in Orleans parish). The name of the reporter shall be deleted from this fax.

J. When the Intake Supervisor needs additional information to determine eligibility, the case shall be maintained by the intake worker in a file folder marked "Pending Intakes". This folder shall be reviewed daily by the Intake Supervisor.

V. PRIORITY SYSTEM

The reports shall be prioritized based on the criteria listed below:

A. PRIORITY ONE

A report which alleges the adult in need of protection is abused, neglected, exploited, or extorted, and has suffered serious harm or serious physical injury which, if untreated, may result in permanent physical damage or death. Examples include but are not limited to head injuries, spinal injuries, severe cuts, broken limbs, severe burns, and/or internal injuries.

Priority One also includes sexual abuse where there is danger of repeated abuse, situations where medical treatment, medications or nutrition necessary to sustain the adult are not obtained or administered, as well as over-medication and unreasonable confinement.

Staff must respond to Priority One cases as rapidly as possible, but within twenty-four (24) hours of case assignment.

Whenever a priority one case is assigned, the Intake Supervisor will notify the EPS Program Manager and the EPS supervisors via email.

B. PRIORITY TWO

A report which alleges the adult in need of protection is abused, neglected, exploited, or extorted, and as a result, is at risk of imminent serious physical injury or harm.

Priority Two reports may include, but not be limited to, situations in which there is failure to provide or obtain behavioral health and medical treatment which, if untreated, may cause serious harm to the adult. This includes self-abusive behavior and failure to treat physical ailments. It could also include inadequate attention to physical needs such as insufficient food, medicine, inadequate heat or excessive heat unauthorized use, and/or exploitation of the victim's income or property which places them at risk.

Staff must respond to Priority Two cases as rapidly as possible, but within five (5) working days of case assignment.

C. PRIORITY THREE

These reports include all other allegations in which the adult in need of protection is alleged to be abused, neglected, exploited, and extorted which do not involve risk of serious physical injury or harm.

Priority Three allegations involve the failure to assure that the victim's basic needs are provided. These needs include, but are not limited to, adequate housing, nutrition, medical and behavioral health needs, proper clothing for the weather conditions, and an environment free of safety hazards. Priority Three reports will also include those situations when verbal and emotional abuse is used as a means of controlling the victim including, but not limited to, harassment, cursing, degrading remarks, intimidation, ridicule, and threatening to withdraw care.

Staff must respond to Priority Three cases as rapidly as possible, but within ten (10) working days of case assignment. The Program Manager or designee may defer investigation of Priority Three due to increased caseloads and/or an inadequate number of staff to investigate them.

D. Special Instructions

When warranted by the allegations in the report, the Intake Supervisor may direct a specific timeframe for attempting face to face contact as well as assigning a priority level. For example, a case may fit the criteria for a Priority Two, but the adult may need to be seen before an approaching weekend to ensure adequate safety. In such case, the Intake Supervisor will provide such instructions in the description section of the intake form and will advise the Specialist of the instructions when calling to inform them of the case. If the Specialist is not in, the special instructions should be included in the message left for the Specialist and in the email sent.

Risk factors that should be considered by the Intake Supervisor when making a determination of case escalation may include, but are not limited to: inclement weather, upcoming holidays or weekends, and/or the proximity of an adult to assistance or services.

VI. EMERGENCY RESPONSE AT INTAKE

If at any time during the intake process it becomes clear that the adult in need of services and requires emergency service or intervention, the intake Specialist shall take the following actions, as appropriate:

A. Immediately notify the Intake Supervisor.

B. If the reporter indicates that the adult is in present, imminent danger and/or serious harm/injury is occurring, the intake Specialist obtains pertinent information and then immediately contacts an emergency number (911 or other law enforcement numbers) and reports the emergency. The intake worker is responsible for follow-up to determine if emergency services were provided.

C. The fact that the report is transferred to another agency for an emergency response does not relieve EPS of responsibility for determining if the adult is eligible for EPS services and, when possible, continuing the intake process. The Intake Supervisor is responsible for assuring that this follow-up occurs.

D. If it appears that the adult may be in need of immediate intervention by EPS, including, but not limited to, removal or placement, the Intake Supervisor shall notify the EPS Program Manager immediately. Assignment and work on the intervention may begin in these cases, even though the normal intake process is incomplete.

VII. ASSIGNMENT OF EPS SPECIALISTS

A primary objective in assigning cases is to balance case assignments over the course of the year. It is not possible to guarantee this due to variations in the number of reports among the regions, number of Specialists in the region, etc. Further, variations in reporting patterns may require that some Specialist receive more cases during a month or quarter. However, the Intake Supervisor and EPS supervisors should monitor the number of cases assigned over the past 30, 60, 90 and 120 days in order to guard against large inequities in case assignment. The Intake Supervisor and the EPS Program Manager may agree on a "target" number of cases per month. Once an individual Specialist has reached that number, consideration may be given to assigning cases outside the region or making other exceptions to the usual assignment criteria.

Cases are normally assigned to an EPS Specialist domiciled within the region where the adult resides. Exceptions to this rule may be made by the Intake Supervisor. For example, if the incident took place in a region other than where the adult resides and the witnesses and/or the accused live in that region, law enforcement is involved, etc. it may be more efficient to assign the case to a Specialist there. A general rule of thumb where these cases are concerned is to assign the case to the region where the majority of the investigation or assessment will need to take place. This will minimize the need for having Specialists in the other region provide assistance.

In regions where more than one Specialist is domiciled, it may be efficient to divide the region geographically and assign cases by parish, particularly in outlying parishes. This may minimize travel by having a Specialist focus primarily on one part of the region. The Intake Supervisor shall consult with the EPS Program Manager regarding regions where this procedure should be followed. This procedure shall be considered a guideline and not a rule. Other assignment criteria should also be taken into consideration so that this does not result in a wide discrepancy in caseload size.

In addition to geographic considerations, assignments are made to EPS Specialists on the basis of the cases assigned to individual Specialists within the previous 30 days. Taking other factors cited in this policy into account, a new case will usually be assigned to the Specialist in the region that has had the fewest assignments during the previous 30 day period.

Another determinant in making case assignments is the date of the previous assignment. Taking other factors cited in the policy into account, assignments are usually given to EPS Specialists in a region on a rotating basis. Those persons with "older" assignments become prime candidates for a new assignment. For example, if two EPS Specialists in a region have the same number of caseload assignments in a given 30 day period and one EPS Specialist received an assignment yesterday; today's assignment will usually be given to the other EPS Specialist.

Some case assignments are determined by the EPS Repeat Case Protocol, which is detailed in the following Section. Generally this provides that *first time* repeat cases are assigned to the same Specialist who had the previous case. For assignment guidelines for *multiple repeats* (3 or more cases,) refer to the Protocol.

Specialists are notified of case assignments via email and telephone. If the Specialist is not in, and the case is priority two or three, the Intake Supervisor/specialist may leave a message notifying the Specialist that the case has been assigned. If the case is a Priority one, the supervisor/specialist must call the Specialist on the cellular phone. Priority one reports received late in the workday must be called to the EPS Specialist at their home or cellular telephone number in order to assist them in planning their schedule so that the face to face timeframe can be met. If the Specialist cannot be reached that day, he/she must be called immediately the following calendar day. If the next calendar day falls on a weekend or holiday, intake personnel will also notify the EPS Specialist's supervisor in the respective region to ensure that the 24 hour deadline can be met. If intake personnel are unable to contact the EPS Specialist or regional supervisor, he/she will notify the Intake Supervisor, or, if not on duty or unavailable, the EPS Program Manager.

While all cases must be assigned as quickly as possible, the Intake Supervisor/specialist may assign the case the next working day if the priority is two or three. Priority two and

three cases may be assigned to Specialists who are currently on leave provided they are expected back at least two days prior to the case response deadline.

VIII. REPEAT CASE PROTOCOL

Repeat cases are a common occurrence in elderly protective services. This is especially true with cases of self-neglect and cases involving adults with behavioral health problems. Repeat cases present a two-fold problem. On the one hand, repeated reports involving the same adult and the same allegation, where the case is repeatedly not substantiated or where the adult consistently refuses services, can be time-consuming and can draw investigative resources away from other reports. On the other hand, just because a report involves the same adult and the same allegation does not mean it is safe to assume the current case will turn out the same. Additional information may lead to substantiation and/or the adult may finally have reached a point where they will accept services.

The following protocol is to be followed when repeat reports are received. In all guidelines outlined below, it is assumed that the adult meets EPS eligibility criteria. Note that the fact that an adult was previously rejected as ineligible does not preclude the adult being eligible at a later date if his/her condition or situation has changed.

A. First time repeat cases should automatically be accepted and should be assigned to the same worker who handled the first case, provided that worker is available.

B. Multiple reports (3 or more separate reports on the same adult) shall be handled as follows:

1. If a report is received while the previous case is still open, it will be handled the same way as any other report received while a case is open.

2. If it has been six months or more since the last case was closed, the case will be accepted. The Intake Supervisor, the EPS specialist who handled the previous cases, and that specialist's supervisor shall confer and shall determine to whom the case will be assigned.

   The case shall be staffed by the assigned EPS Specialist, his/her supervisor, and any EPS Specialist(s) who worked the previous cases. If appropriate, program office staff or others involved with the adult may be included in this staffing. The purpose of the staffing is to review what evidence has been obtained and/or what interventions have been tried in previous cases and to

develop ideas for appropriate investigation and/or intervention in the present case.

3. If it has been less than six months since the last case was closed and the finding on the last case was substantiated or unsubstantiated with concerns, the case will be accepted and the procedure outlined in (B) will be followed.

4. If it has been less than six months since the last case was closed, the report involves the same allegation, the same accused and the previous report was unsubstantiated, or the adult refused services, the intake Specialist will gather as much information as possible about any changes in the situation as it was reported before. This will include at a minimum the following information:

    a. Has the adult's behavioral or health status changed and, if so, how?
    b. Has the adult's living situation changed and, if so, how (e.g., new location, new persons in household, loss of or change in caregiver, etc.)?
    c. Has any other factor regarding the adult's situation changed and, if so, how (e.g., is the adult no longer receiving services, is the adult not receiving medications or treatment, etc.)?
    d. Is the reporter the same?
    e. Is there any reason to suspect the reporter's motives?

If there is an obvious change in any factors which might place the adult at risk, the case will be accepted and assigned. If the intake Specialist is unable to determine if any factors have changed, the report will be referred to the EPS Specialist who last had the case. The EPS Specialist will make a follow-up visit or phone call to the adult and report back to the Intake Supervisor. The Intake Supervisor will confer with the or the EPS Manager to determine whether to open a new case. In making this determination, in addition to considering risk factors, previous case reports may be reviewed to determine whether the investigations were thorough and/or whether the services offered seemed adequate to address the adult's needs.

If the decision is made not to open a case, the reject report shall document that contact was made to ensure that the adult was safe and/or that the adult continues to refuse EPS assistance, and that any appropriate referrals were made. This information shall also be added to the most recent case file.

C. Cases on monitoring status. Reports received regarding cases on monitoring status will be handled as follows:

1. If the report involves a new allegation or a new accused, a new case will be opened and assigned to the EPS Specialist who is monitoring the case.

2. If the report involves the same allegation(s) and the same accused, the information will be forwarded to the EPS Specialist monitoring the case for follow-up. After the follow-up, the Specialist will advise intake if a new case needs to be opened.

It is **not** expected that this protocol will result in a substantial decrease in the acceptance of repeat cases as it is often difficult or impossible at intake to be sure if any significant factors about the case have changed. Since any change could conceivably place the adult at risk, intake Specialists should err on the side of accepting reports. However, this protocol should provide a mechanism for ensuring that problematic or "revolving door" repeat cases are thoroughly staffed and reviewed.

VIII. CAPACITY

Capacity to consent is the ability to understand and appreciate the nature and consequences of making decisions concerning one's person, including, but not limited to, provisions for health or mental health care, food, shelter, clothing, safety, or financial affairs. In EPS non-licensed and provider cases, Specialists must screen every client for capacity to consent to protective services. When clients are at risk of serious harm and cannot or will not consent to the services needed to remedy that harm, the EPS Specialist must take additional steps to assess and evaluate capacity.

I. CAPACITY DETERMINATION

While a definitive capacity assessment can only be made by a physician or trained behavioral health professional, EPS Specialists must make an informed judgment about client capacity and then, as appropriate, obtain further professional assessments.

The proper assessment of capacity ensures protection of those clients who cannot protect themselves but also respects the right to self-determination of clients who have capacity and choose to remain in situations that put them at risk of harm. EPS provides involuntary services only when clients who lack the capacity to consent to services are in danger of serious harm or death. Proper assessment of capacity is also important in cases where the risk of danger may not be high. It aids in determining the degree to which clients can communicate accurate information about their situation and participate in service planning.

EPS Specialists may assess capacity to consent using casework skills including, but not limited to, interviews with the client and collaterals and observations along with the techniques listed below. This is especially true when clients are at risk of serious harm and refuse services needed to remedy that harm.

II. TECHNIQUES

A. Multiple Client Visits

It is often necessary to interview clients more than once to get a realistic assessment of client capacity. Acute medical and psychiatric conditions, medications, environment and other factors can affect capacity and may require the EPS Specialist to interview the client under different conditions in order to accurately assess capacity.

B. Review of Past Evaluations

When clients have a diagnosis of behavioral illness, intellectual disability, brain injury, dementia, delirium or any other condition that impairs thinking, the EPS Specialist shall attempt to obtain the evaluations related to that condition as well as speak with the medical professionals who made them or who currently treat those conditions. Clients

receiving publicly funded support services from agencies such as OCDD, OBH, or OAAS should have evaluations and plans of care on file with those agencies. Specialists shall routinely request and review these records to assist in determining capacity.

C. Referrals for Evaluation

When clients have not been evaluated for conditions that may impair capacity or existing evaluations do not address the client's current status related to capacity, the EPS Specialist should attempt to obtain an evaluation from a physician or a psychologist. It is critical that the EPS Specialist inform the physician or psychologist about the nature and scope of the situation or decision for which capacity to consent is in question. It is also important to share any other information about the client which may be helpful in conducting a comprehensive assessment such as home environment, past medical history, current medications and treatments, social interactions and supports and substance use/abuse issues. When clients appear to lack capacity and are at risk of serious harm or death, but refuse to be evaluated for capacity, the Specialist must consult with the supervisor about the need to petition the court to order an evaluation.

D. Structured Interview Questions

The EPS Specialist must include specific questions in the client interview that elicit information that indicates capacity or lack of capacity. Each question must address an identified problem and how the client plans to respond to it. This series of questions must be structured in such a way that the responses will show whether the client has a clear understanding of the problem and the consequences of their response to that problem. At a minimum, the EPS Specialist must ask capacity questions related to each of the substantiated allegations in the report and any other problems discovered in the course of the investigation.

The EPS Specialist must determine whether the responses are appropriate and practical. This means that the response to each question is complete and reasonable and the client appears able to carry out whatever the plans described in their responses. Examples of capacity questions are:

1. If you discovered that your [insert house, apartment, trailer, etc.] was on fire what would you do?

Probe until clients explain fully how they would get to safety and contact the fire department (or until they can offer no further information). This question refers to a major fire; redirect clients if they assume it is a small fire that they can extinguish.

2. What would you do if you didn't receive your monthly checks?

Probe until the clients explain fully how they would resolve the problem and how they would meet their living expenses until the checks resume (or until they can offer no further information).

3. What would you do if you became so sick that you couldn't cook or clean? Or: What would you do if your [insert role of caretaker, for example, housekeeper, son, niece, etc.] didn't show up for three days and there was nobody to cook or clean for you?

Select question appropriate for client's situation. Substitute another appropriate activity if cooking or cleaning is not an assisted task. Probe until clients explain fully how they would ensure they had meals and that essential household chores would be done (or until they can offer no further information).

4. If you had a serious medical emergency and you couldn't contact a doctor what would you do?

Probe until clients fully explain how they would handle the medical emergency (or until they can offer no further information). If clients are unclear about what constitutes a medical emergency, give a broken leg as an example.

Probe until clients fully explain what they are going to do (or until they can offer no further information).

Ask follow-up questions to each question. If the client has no reasonable plan for any of the five questions, the Specialist asks:

5. What do you think will happen if you don't do anything about [insert alleged or identified problem]?

Probe until clients fully explain what they think the consequences of their plan will be (or until they can offer no further information).

E. Consultation With Supervisor

After gathering all available evidence regarding the client's capacity the EPS Specialist discusses the findings with his or her supervisor. They consider the level of risk and the findings regarding client's capacity in order to determine whether a legal intervention is appropriate. If they determine a legal intervention is appropriate, the supervisor obtains approval from the EPS Program Manager, and consults with GOEA General Counsel.

III. THOROUGH DOCUMENTATION

While proper documentation is always important, documentation regarding client capacity requires special attention to completeness and accuracy. Any medical,

psychological or other evaluations on which capacity assessment is based must be included in the case file and referenced in the assessment section of the report. All observations and information provided by collaterals must also be included in the assessment section as well as specific questions related to capacity assessment and the client's responses. While it may not be possible to record the client's exact response, documentation of client responses should be as accurate as possible.

When clients lack capacity or appear to lack capacity but are not at risk of serious harm, the EPS Specialist attempts to link them to all available services and natural supports that would reduce risk and documents his or her efforts. When clients have capacity and are at risk of harm and refuse services to reduce that risk, the EPS Specialist should ensure that they clearly understand that risk and document their understanding. These clients should be asked to sign a Service Refusal Form acknowledging that they were offered services and chose not to accept them.

IX. INVESTIGATION & ASSESSMENT

EPS Specialists conduct timely and thorough investigations of all allegations of abuse, neglect, self neglect, exploitation, and extortion of adults with disabilities, and/or LDH adults reported to EPS. The purpose of an EPS investigation is to determine if the situation and condition of the adult warrants protective intervention. These investigations include; a comprehensive assessment of the adult's situation and each allegation, a decision regarding the adult's capacity, and a determination of the level of risk to the adult.

By law, investigation and assessment shall include: (a) the nature, extent and cause of any abuse, neglect, self neglect, exploitation, or extortion, (b) the identity of the person or persons responsible, if known, (c) an interview with the adult and (d) an assessment of the adult's home, and (e) consultation with other parties who may have knowledge of the facts of the case.

Except where otherwise noted, the policies and procedures in this chapter apply to Non-Licensed and private Provider cases only. Specific procedures for provider and facility investigations are referenced in Chapter 10.

I. PREPARING FOR THE INVESTIGATION

Consultation with the supervisor prior to a Specialist beginning an investigation is required on the following types of cases:

A. Multiple (3) repeat cases on the same adult,

B. Cases involving unlicensed facilities,

C. Priority 1 cases,

D. All cases referred to law enforcement at intake (physical and sexual abuse), or

E. Any case where emergency intervention or removal may be necessary.

Except in situations requiring immediate response, the following steps are taken in preparation for an investigation:

A. Review existing EPS case records.

B. Obtain and review records or information pertinent to the investigation and/or assessment, including:

1. Medical and psychiatric evaluations
2. Substance abuse treatment records
3. Information about income and benefits including name of payee
4. Treatment records
5. Contact information for family members, friends, and other persons who can provide information and assistance
6. Contact information for medical and social service providers
7. Legal records, including those related to interdiction
8. Information about LDH services for which the adult may be eligible
9. A copy of the waiver plan of care from the regional home and Community Based Services office when the adult participates in a home and Community Based Services program

C. Contact the reporter (if known) to verify or clarify the original report, address safety issues, etc. Inability to make contact with the reporter is not a legitimate reason to delay the face to face contact beyond the time frames set by the priority of the case. If the reporter cannot be contacted, the EPS Specialist documents the date, time and method of attempted contact.

D. All cases with allegations of physical or sexual abuse are reported to the parish sheriff's department at the time of intake. The Specialist should make contact with the sheriff's office as soon as possible after receipt of the report to determine if law enforcement is going to investigate the alleged incident. Cases may be transferred to other local law enforcement agencies who have jurisdiction. It may be necessary to determine which law enforcement agency has jurisdiction as well. Other cases involving possible criminal activity, such as exploitation, shall also be reported to law enforcement by the Specialist.

   The Specialist may be asked to conduct a joint investigation with law enforcement. If law enforcement requests that the Specialist allow them to investigate first, the Specialist complies and resumes the investigation as soon as law enforcement has completed their investigation or indicated that is appropriate for the Specialist to proceed. In either case, The EPS Specialist asks to be kept informed of law enforcement's findings and coordinates services (such as emergency removals) in order to protect the adult.

If law enforcement decides not to investigate, the EPS Specialist documents the time and date law enforcement was notified and the result of the contact. See the section labeled *Cooperation with Law Enforcement* in this chapter.

E. Develop an investigation strategy based on the intake information and any other information received after the intake including:

1. Who will be interviewed?

2. Questions for each interviewee

3. Physical/Demonstrative evidence, such as - written records, photographs or physical evidence

4. Worker safety issues – always be alert and concerned about safety

5. An approximate time line – follow approved priority time lines

F. Make every effort to determine if the visit to the adult's home will put the adult at further risk of harm. If it appears that it will, discuss the case with the supervisor to determine what course of action to take. Unannounced visits are the preferred form of contact. If it is possible to telephone the adult without alerting the accused, it is acceptable to call the adult prior to the visit to ensure he or she is there. In some cases, it may be preferable to conduct the initial interview away from the adult's home. This will assure privacy from the accused and may encourage the adult to speak more freely. This may be possible in cases where the adult attends a day program, clinic, school, etc.

G. Identify and respond immediately to medical and other life threatening emergencies. When information received at intake or otherwise prior to the face to face contact indicates that the adult is in a situation that poses an immediate threat to life or serious harm, arrange appropriate medical or other services to resolve the crisis or assist family, friends or care givers to do so before completing the initial interview. For example, if a reporter says the adult is experiencing chest pains, direct the reporter to call an ambulance.

H. Ensure that all equipment needed to conduct the investigation is in working order (e.g., camera, tape recorder etc.).

II. MAKING FACE TO FACE CONTACT

The EPS Specialist is to make a good faith effort to conduct a face to face visit with each adult within the time frame according to the case priority.(see Chapter VII, Intake)

The priority system sets the maximum allowable time-frames for this contact; however, EPS Specialists are required to attempt the face to face contact *as soon as possible* after receiving the report. These attempts include, *in order of preference;* multiple visits, phone calls, attempts to locate the adult via family, friends, neighbors, etc., attempts on weekends or after 4:30 p.m. on weekdays. Attempts should continue until the adult is located or it is established he/she cannot be located.

Appropriate case response means making a rapid, consistent, good faith, and documented effort to locate and protect the adult. It does not include violating the adult's confidentiality by offering information about allegations or leaving information about the protective service investigation in unprotected circumstances. Specialists are not to leave their business cards at the adult's homes during an investigation, especially when contact has not been made previously or the accused resides at the same address. During the service phase of a case, if the adult is no longer at risk of harm, retaliation, or influence by the accused, business cards may be left provided they are placed in a sealed envelope.

An EPS Specialist who cannot make the face to face contact within the time frame shall notify the supervisor prior to the expiration of the time frame. The supervisor may grant an extension. The EPS Specialist also notifies the supervisor when the first face to face attempt is unsuccessful. Prior to making additional attempts, the EPS Specialist should contact the reporter or other persons with knowledge of the adult's situation/ schedule for any additional information that may be helpful in making contact with the adult.

Other attempts should also occur within the time frame for the priority, with consideration given to the specifics of the situation. For example, for a priority 1 case, an additional attempt is made no later than 24 hours from the first attempt. For a priority 2 case, an additional attempt is made no later than 5 days after the date of the first attempt.

Only in the most extreme cases will failure to make the face to face interview with the adult be acceptable. Examples include death of the adult or other factors that place the situation totally beyond the control of the EPS Specialist. If the adult cannot be located after all reasonable attempts, assistance from law enforcement should be requested. All attempts to interview the adult shall be thoroughly documented and supervisory and EPS State Office approval shall be obtained before attempts to contact the adult are ended.

When conducting EPS business the EPS Specialist always wears a GOEA identification badge and identifies himself or herself by name and as an employee of EPS.

The EPS Specialist may encounter resistance from adults when conducting the face to face contact. The first sign of resistance should not be a reason for stopping the investigation. Adult resistance can often be overcome by emphasizing the helping role of EPS, the agency's legal mandate (right) to investigate and by establishing rapport with the adult. It may be necessary to make multiple visits before some adults are willing to

discuss the allegations. In some cases it may be helpful to arrange for law enforcement or a person familiar to the adult to accompany the EPS Specialist on the visit to facilitate entry. If the adult still refuses to grant the EPS Specialist entry, contact the supervisor to discuss how to proceed.

Adults who have not been adjudicated incompetent and clearly demonstrate they have the capacity to consent to services may refuse to be interviewed regarding the allegations. This does not remove the Specialist's responsibility to make every effort to assess the adult's situation and determine whether or not the allegations are correct. If an adult requests that the Specialist stop the investigation out of concern that it will make the situation worse, the Specialist shall consult with the supervisor.

Adults with capacity may refuse services at a later point in the case. In these cases the EPS Specialist documents the refusal and the basis for the determination that the adult has the capacity to consent. Documentation of capacity to consent must show that the adult clearly understands the allegations and the potential consequences of the refusal. Simply stating that the adult has capacity is not adequate documentation. Whenever possible, statements from collateral contacts, physicians or other professionals with knowledge of the adult's capacity should be included to support the determination. If possible, the EPS Specialist obtains a signed refusal of services form and gives the adult information on how to contact EPS should he or she decide to accept our assistance at a later date.

In cases where the adult lacks or may lack the capacity to consent, and is denying the EPS Specialist entry and the EPS Specialist has exhausted all means to facilitate entry, the supervisor is to be consulted to discuss legal intervention to gain entry.

Note: If at anytime during the investigation it becomes apparent that the specialist or their immediate family has a prior affiliation with any party involved in the investigation, the specialist shall immediately notify their supervisor. A decision will be made about reassignment of the case based on the information provided.

III. INVESTIGATIVE REQUIREMENTS

I. The EPS Specialist shall:

A. Determine if interpreter services are needed and arrange for it.

B. Obtain signed release of information forms from the adult giving permission to access any relevant records, reports or any other information pertinent to the case.

C. Determine if emergency medical services are needed. If so, access services necessary to stabilize the situation. In some case it may be necessary to arrange for, or facilitate emergency medical treatment even before the face to face contact.

D. Conduct a thorough assessment of the adult to determine degree and severity of injury, illness, or harm. (In case of injury, a medical assessment should be obtained.) If one has already been done, obtain a copy of the evaluation.

E. Take photos of any injuries or relevant conditions if possible (after getting permission from the adult). If permission is not given, then document the attempt and refusal and take notes describing the injuries.

F. Observe the adult's environment and food supply, and ensure that the utilities are operational.

G. Interview the adult, the accused, the caregiver, family, or others who are or were responsible for or assisting with the care of the adult, and/or collateral contacts who may have knowledge of the alleged incident or have information pertinent to the allegations or adult's general situation. If possible interview in the preferred order: the reporter; the adult; other witnesses; other collaterals, including; neighbors, Doctors, Case Managers, etc.; lastly, the accused.

If a person refuses to participate or cannot be located after a "good faith effort", then document all efforts and refusals in the report. The accused must be interviewed unless it puts the adult at risk of harm or law enforcement has requested that they handle the interview alone.

H. Interviews shall be documented on witness or interview forms. Use the Witness Statement form for actual statements of witnesses or collaterals. Such statements are required in cases involving provider investigations and in cases referred to law enforcement at intake. When a written statement is not required, use the Interview Form. When the witness statement is used, the witness should complete the Witness Statement form with a complete statement guided by the interview questions or, in instances where the witness is unwilling or unable to write a statement, the specialist should complete the statement using a question and answer format and ask the witness to sign or mark the statement after reading it or having it read to him.

I. In cases which involve or are impacted by medical factors, review the adult's medications.

J. In cases involving exploitation and/or extortion or where finances or legal issues impact the adult's situation, review any financial or legal records.

K. Collect physical or documentary evidence pertinent to the investigation

L. Where appropriate, seek an evaluation of the incident from professionals, such as physicians, for a clearer understanding of the adult's condition, evaluation of capacity, evaluation of injuries, treatment plans and any other information needed for a thorough investigation and comprehensive assessment.

M. Conduct a comprehensive assessment of the adult's general situation including, environment, medical conditions, mental conditions, finances and social supports to determine root causes of the adult's problems.

N. Document all of your contacts and activities under the activity tab in the electronic record, giving date, and a brief summary of the activity or contact. Document the investigation findings under the assessment section in the narrative.

IV. GUIDELINES FOR CONDUCTING INTERVIEWS

The recommended order for interviewing persons associated with the case is as follows:

A. the reporter,
B. the adult,
C. witnesses/collateral contacts,
D. the caregiver,
E. the accused.

The inability to interview the reporter does not delay face to face contact timelines.

The initial contact with the adult is unannounced if possible. When the EPS Specialist is unable to make an unannounced visit, he or she documents all efforts to do so and continues to attempt to contact the adult by telephone to arrange for a home visit.

The alleged victim is interviewed in private if they are able to communicate without an interpreter. If interpreters are necessary, the interpreter should not be a party to the case. Communicative devices/application shall be used by the specialist to ensure all information received is accurate. The EPS Specialist does not conduct a joint investigative interview with the alleged abuser and the alleged victim. The accused is also interviewed in private, subject to any concerns about worker safety, involvement of law enforcement, etc.

When someone is resistant to the interview process the EPS Specialist can try the following techniques; developing rapport, emphasizing the agency's role in assisting disabled persons, and explaining that we have a legal mandate (right) to conduct investigations. Law enforcement officers may be able to help convince the interviewee of the legal necessity of cooperation with the investigation. If all efforts to secure

cooperation with the interview process fail, the EPS Specialist consults with the supervisor.

The name of the reporter is always kept confidential. It is released only to law enforcement or to the court, when necessary, for legal action.

The interview questions shall address all reported allegations as well as the adult's environment, medical and mental condition, finances, social relationships and any other factors related to protection.

A careful assessment of the adult's capacity to consent to services is part of the assessment process. It not only relates to the adult's ability to refuse services but also is a context in which to interpret the adult's ability to accurately communicate information and the degree to which he or she can participate in service planning. (See Chapter VIII, Capacity)

Interview questions, whenever possible, should be open ended, to avoid leading the interviewee. Using who, what, where, when and how questions ensures that they are not closed ended. An interview should be paced so that the interviewee can adequately respond to the interview questions.

During the interview, balance the development of rapport with keeping the interview focused on the allegations. As needed, probe for additional information, ask follow-up questions and redirect the interviewee in order to obtain complete, clear and accurate information.

Be attentive to non-verbal communication during the interview and respond to it as the situation dictates.

When the interview is completed, briefly summarize what was accomplished and what steps are next.

V. DEATH CASES

If an adult dies prior to or after an investigation has begun and the adult's death is unrelated to the allegations, or there is no reason to continue the investigation (no criminal acts are involved) and EPS Supervisor and EPS Program Manager approval has been secured, the case may be closed.

A. If the adult dies prior to an investigation beginning and there are allegations of A/N/E/E that are suspected to or potentially have attrituted to the adult's death, the Specialist will:
   1. Notify Law Enforcement and/or the District Attorney immediately.

B. If the adult died during the course of the investigation and there is reason to believe the death may have been related to maltreatment, if EPS is notified timely, the Specialist will:
   1. Notify Law Enforcement and/or the District Attorney immediately.
   2. Contact Home Health, Hospice or Hospital when deemed necessary.
   3. Conclude the investigation unless directed otherwise by Law Enforcement and or the District Attorney
   4. Obtain the cause of death.

VI. FORMULATING THE INVESTIGATIVE FINDINGS

Evaluate the evidence gathered in the investigation process regarding the allegations received in the report and any abuse, neglect, exploitation or extortion discovered in the course of the investigation and determine whether there is a preponderance of evidence to support substantiation.

A. Review all evidence gathered during the investigation and conduct follow-up interviews, when additional information or clarification is needed. Evidence that should be evaluated includes:

   1. The adult's account of the situation.

   2. Information supplied by witnesses and collateral contacts.

   3. The accused's account of the situation.

   4. All relevant records, photographs, physical evidence and documents.

B. Evidence is grouped by allegation and organized into what is agreed upon by all parties to the case and what is not agreed upon. Of the evidence in dispute, determine which evidence is more credible and document the reasons why. Credibility is not based on an assessment of a person's character but rather whether the facts he or she presents are believable. Consider consistency of account, motivation to be untruthful, proximity to the alleged abuse, and plausibility of the explanation of an event when assessing credibility.

C. Determine if there is a preponderance of evidence to support one account over another. A preponderance of evidence means that it is more likely than not that an event occurred or did not occur (that is, more than 50% of the evidence supports the finding). In addition to whether the event occurred, it must meet the definition of abuse, neglect exploitation and extortion to be substantiated. The intention of the accused is not to be considered in concluding whether or not an event is substantiated.

VII. COOPERATIVE INVESTIGATIONS

There are certain circumstances where the situation which presents A/N/E/E to a disabled adult also violates the regulations of another regulatory agency or involves adults of another agency. In those situations EPS performs a cooperative investigation with the other agency(ies). EPS staff should make the effort to complete an investigation within policy guidelines while offering whatever assistance is possible to investigators of other agencies.

EPS has a memorandum of understanding with the following agencies:

Governor's Office of Disability Affairs (GODA)

Office of Citizens with Developmental Disabilities (OCDD)

These agreements govern how EPS handles cases in these programs. EPS also conducts investigations for the Office of Behavioral Health (OBH) for their Access to Recovery (ATR) and Mental Health Rehabilitation (MHR) programs. EPS works cooperatively with such agencies as the Office of Public Health and local health departments, Office of Children's Services, Health Standards, etc. Each agency, however, will be investigating issues specific to their responsibilities. We will investigate whether or not the adult has been the victim of A/N/E/E. Home and Community Based Services will be evaluating the performance of a home and Community Based Services service provider according to their provider agreement and the adult's comprehensive plan of care. OPH may be looking into sanitary situations in the home. Coordinating investigative efforts and sharing findings becomes important when reaching an outcome which is the least restrictive for our adult.

VIII. PROCEDURES FOR COOPERATIVE INVESTIGATIONS

The agency name will be included in the intake description of a joint investigation. If, at any time during an investigation, a Specialist becomes aware of a concurrent investigation by another agency, this information should be brought to the supervisor's attention and included in data entries when they are submitted.

Timelines for cooperative investigations do not change. If some parts of the joint investigation cause delay, it may be necessary to request an extension for completing the case.

When issues are similar, interview adults, witnesses and the accused jointly with personnel from the other agency. This will avoid repetition and the interviewee developing a well rehearsed story.

As in special request investigations, we may share information with the other agencies which are completing investigations and/or provide them with copies of our reports.

IX. ADULT RESIDENTIAL CARE FACILITIES

Cooperative investigation may also involve joint assignment of Specialists from appriopriate agencies, such as the investigation of unlicensed group homes, board and care homes or adult residential care facilities.

In these cases, the EPS Specialist is to focus on determining whether or not abuse/neglect took place and developing a service plan for the adult(s) while the appropriate investigations Specialist will try to determine if the operator of the group home has or should have an adult Residential Care Provider license. HSS is the licensing agency for these types of homes, under R.S. 40:2166.5(B) (11).

According to HSS licensing standards, providing anything more than room and board (such as assistance with medication, transportation, etc.) for 2 or more people unrelated to the owner, in order to receive compensation, requires licensure.

Each agency should create an electronic case file on each adult impacted by the allegations. Specialists from each agency should share information with each other freely to avoid duplication of effort. Timelines for case completion are the same as other Non-Licensed and Provider cases respectively.

Upon arrival, the EPS Specialist is to obtain or attempt to obtain identifying information on all residents, including names, SSNs, representative payee information, bank account information, next of kin information, any day programs attended, medications, etc. The EPS Specialist should determine what personal care services are being provided, the amount each resident is being charged and how the operator receives payment.

X. HOME AND COMMUNITY BASED SERVICES RECIPIENTS

When the adult receives Home and Community Based Services, but the accused is not a provider of these services, EPS will investigate the allegations. If, during the investigation/assessment, it becomes apparent that the allegations are actually the fault of a paid provider of services (or if any new allegations are discovered against the provider) the Specialist notifies the supervisor. The supervisor consults with the EPS Program Manager to determine if the case will be transferred to the Investigations Division of LDH.

A. In order to effectively investigate in these situations it is important to review the adult's current Home and Community Based Services service plan. The

assessments and plan for each adult should comprehensively outline the areas where the recipient needs and is receiving supportive services. In many of the substantiated cases of A/N/E/E, the solution to the problem is a change of services and a revision of the care plan. Sometimes the solution is to identify services the adult is already receiving which are not having the intended effect.

B. Specialists are to contact the regional Home and Community Based Services staff before beginning an investigation involving An adult receiving Home and Community Based Services. This person should be able to supply the name and contact number of the adult's support coordinator, as well as the most current approved plan of care. Ask for the most recent information about the complaint situation. It may be necessary to contact the support coordinator for current information about the adult as well as the reporter of the complaint before the actual investigation begins.

C. Whether or not the original referral came from the Home and Community Based Services office, keep the Home and Community Based Services Regional Office aware of situations involving their adults and involve both the regional office and the support coordinator in planning for services to eliminate and prevent the recurrence of A/N/E/E.

D. Review the care plan to see if the area of concern in the complaint is addressed. The care plan is supposed to include all areas of concern, the supports or services to address them and the person responsible for providing them. If there is an area where the adult is found to need assistance as the result of our investigation, EPS should request changes be made to the care plan to remedy A/N/E/E in addition to other service referrals necessary.

E. For example, when investigating sexual abuse, try to determine whether or not the abuse took place. Also, look into the adult's capacity to consent if the activity was not forced. Are the adult's sexual behaviors or activities addressed as a problem area on the care plan? Do the assessments indicate whether or not the adult has a history of sexual activity, flirtatious or sexual behavior, a significant other? Does the staff or the support coordinator have information about this issue? Does the adult need training in the areas of social and sexual behavior? If they are to engage in consensual behaviors do they have knowledge of contraception, STDs, etc.? Any needs not currently addressed in the plan of care should be brought to the support coordinator's attention.

F. In the instance of financial exploitation or extortion, does the care plan identify who is responsible for managing the adult's money? A comprehensive assessment would state whether or not the adult has demonstrated competency in handling

finances. If the adult is learning to manage his own finances, who is responsible for assisting him? If it is a family member or other payee, EPS would investigate, and make appropriate recommendations regarding the adult's finances that may be added to the care plan as part of meeting the adult's comprehensive needs as a part of service planning.

G. Similarly, when investigating neglect or self-neglect it is necessary to determine who is responsible for providing care. If the adult is responsible for bathing, dressing, etc. and it is not being done adequately it may be necessary to assign these tasks to someone else, either a Home and Community Based Services provider or other caretaker. If the adult has been determined to be unable to perform self care, the care plan should indicate who is responsible.

Keep in mind that recipients of Home and Community Based Services have been determined not only to have disabilities, but also to be in need of the level of care provided in an institutional setting. Therefore, they may be in need of more services than those individuals who live more independently. Many times it will be necessary to add home and Community Based Services provider services as all or part of the solution to the problems we investigate.

If there is a finding of substantiated or unsubstantiated with concerns in any case, request a joint staffing with the Home and Community Based Services unit, the support coordinator, OCDD (if appropriate), and, if appropriate, the provider. Your service plan, recommendations and concerns should be shared. EPS concerns should be incorporated into the adult's plan of care and the support coordinator should assume responsibility for implementation. Ask the support coordinator to notify you when the changes are put in the plan.

All recipients of Home and Community Based Services are to be identified as such in the incident description portion of our data base and the adult screen in the data record. When the adult is not identified as a Home and Community Based Services recipient at intake, it is the responsibility of field staff to add it.

XI. COOPERATION WITH LAW ENFORCEMENT

The APS law mandates reporting all cases of physical or sexual abuse to the primary law enforcement agency in the parish where the event took place by the end of the next business day after the report is received. These reports are made at intake when the case is assigned to the Specialist. Intake uses an electronic form letter which includes the name of the assigned Specialist and their office phone number. The electronic record should be updated to reflect notification was sent. Reporters will be told at intake that

the law requires us to notify law enforcement of all allegations of physical or sexual abuse.

WHEN YOU RECEIVE A CASE INVOLVING PHYSICAL OR SEXUAL ABUSE, CONTACT THE LAW ENFORCEMENT AGENCY AND OFFER TO CONDUCT A JOINT INVESTIGATION. Some law enforcement agencies will conduct a joint investigation, while others will follow on the referral independently. However, each agency should continue to be contacted whenever a case is assigned in order to encourage joint investigations.

In other cases where the allegation includes a criminal event, such as financial exploitation or cruelty to the infirm, the Specialist is to report the complaint to the law enforcement agency with jurisdiction. In these instances, we are to cooperate with law enforcement during their investigation and, whenever possible, investigate jointly. Some law enforcement agencies have staff with specialized skills in investigating sexual abuse or financial exploitation.

XII. CASES WHICH INVOLVE MULTIPLE REGIONS

Some cases may cross regional lines. For example, An adult living in one region may be abused while visiting a family member in another region or a case may have collateral contacts living outside the region. In such cases, it may be efficient for Specialists in other regions to conduct portions of the investigation. The Specialist who is assigned the case is to contact his/her supervisor to initiate such a request. The supervisors of each region will coordinate the request and set an expected completion date. The Specialist initiating the request is responsible for following up after the completion date to discuss the results.

A. Transfer of Cases During the Investigation

1. **Transfers Between Regions** - When the adult moves to another region while the case is open, the following shall occur:

    a. The original specialist shall immediately notify his/her supervisor of the adult's move.

    b. The supervisor shall immediately consult with the EPS Program Manager to determine if the case should be transferred. If so, the EPS Program Manager shall notify the intake supervisor of the move and the two will determine which specialist in the new region will be assigned the case.

c. The original supervisor shall notify the receiving supervisor of the case transfer. The receiving supervisor shall notify the receiving specialist.

d. The Intake Supervisor will change the case assignment in the EPS database. The original specialist must update the electronic record before the case is transferred in the database.

e. The receiving specialist shall immediately contact the original specialist, who shall forward all relevant information obtained to that point in the case to the receiving specialist. The information shall be forwarded as soon as possible, but at least within five (5) working days. If additional information needed to complete the case is located in the original region (e.g., a collateral contact to be interviewed) and is most efficiently obtained by the original specialist, he/she may be required to obtain this information and forward it to the receiving specialist. Such information shall be forwarded within five (5) working days.

2. Timelines for Contacting The Adult When Case is Transferred

a. If the initial face to face contact with the adult has not been made and the original deadline has not yet arrived, the receiving specialist shall adhere to the original deadline. If unable to meet the deadline, contact the supervisor in advance so that an extension may be obtained.

b. If the initial face to face contact with the adult has not been made and the original deadline has passed, the receiving specialist shall attempt to make face to face contact with the adult as soon as possible, but within two (2) working days of receiving the case. If unable to meet this deadline, contact the supervisor in advance so that an extension may be obtained.

c. If the initial face to face contact with the adult has already been made, the receiving specialist shall visit with the adult as soon as possible, but within five (5) working days of receiving the case. If unable to meet this deadline, contact the supervisor in advance so that an extension may be obtained.

d. Where there is reason to believe the adult may be at risk of harm in the new situation, the receiving specialist may be required to see the adult sooner as directed by the supervisor.

B. Responsibility for Completion of Case

1. Except as noted elsewhere in this procedure, once the case is re-assigned the receiving specialist is responsible for all remaining work on the case including, but not limited to, implementation of any services and completion of the database, risk assessment, and narrative report.

2. The receiving specialist shall complete the case and documentation within the required timelines as provided in EPS policy, unless an extension is requested and approved.

Special Situations

1. When an adult moves after an investigation is complete and all allegations have been determined to be unsubstantiated, there is no need to transfer the case. The original specialist will complete the case. If there is reason to believe the adult is now at risk of harm because of the new situation, a new report shall be called in to intake.

   When an adult moves to another region (either before or after EPS intervention) as a way of leaving an abuse/neglect or at risk situation, there is no need to transfer the case. For example; an adult is found to have been abused/neglected by a caregiver, and upon either the adult's or family's initiative or as part of the service plan, the adult goes to live with a relative in another region. In such a case the original specialist will complete the case. If necessary, the original specialist may contact his/her supervisor to initiate a request that a specialist in the new region check out or verify the new living situation, that services are in place, etc. In such cases the information will be forwarded to the original specialist for inclusion in the case record.

X. SERVICE PLAN

The characteristic which is unique to the EPS program is developing an intervention or service plan to alleviate the A/N/E/E which prevents adults or adults with disabilities from living independent lives in the community. Service plans are developed in conjunction with other agencies or sources of support in the community which are responsible for providing the services.

I. CASE INTERVENTION/SERVICE PLAN

During the investigation/assessment phase of the case, the EPS Specialist shall identify the problems or risk factors contributing to the abuse, neglect, exploitation or extortion of the adult. As each problem/risk factor is identified the EPS Specialist shall determine what action is needed to address it. One of the tools used during this phase is the Risk Assessment Form. In some cases crisis intervention must be taken immediately as the adult is at imminent risk of harm. Case interventions can be anything from a court-ordered removal of an adult to a referral to another agency. Case interventions can include actions taken by the EPS Specialist, other agencies, relatives or friends, caregivers or even by the adult, which reduce risk or provide protection. These actions may be taken immediately or may be on-going. Additional examples of case interventions include but are not limited to: changing the payee for the adult's Social Security and/or SSI check(s), placing the adult in LDH custody, obtaining a restraining order, obtaining food, medicine, shelter or utilities for the adult, assisting the adult who voluntarily seeks medical treatment, etc.

Case intervention or an explanation of why there is no case intervention is required on all cases where at least one of the findings is substantiated or unsubstantiated with concerns. These actions would be listed in the Protective Service Plan section of the case narrative along with any other steps needed to stabilize the case.

A. Adult Participation

All aspects of the service plan are developed with the ongoing participation and involvement of the mentally competent adult. Case resolution is adult focused, individualized, and based on a social work model of problem solving as opposed to a prosecutorial or law enforcement approach.

B. Obtaining Services

The goal of the EPS Specialist is to obtain services for the adult in the least restrictive setting available that will provide the adult with needed care, treatment and services sufficient to protect the adult from harm and allow the adult to function as independently as possible. The EPS Specialist is responsible for obtaining these services and making referrals for assistance through LDH or through other state or federally funded programs, local churches, civic organizations, etc.

C. Referral for Services

The EPS Specialist shall make referrals to other agencies and shall ensure that the services necessary to protect the adult are provided. In some cases the EPS Specialist may be required to assume the role of a case manager when these services are not available and when the service is necessary to stabilize the case. For all adults with a possible diagnosis of Developmental Disability, the EPS Specialist will assist the adult to obtain services from OCDD. If the adult has not been diagnosed and evaluated (D&E), then the EPS Specialist will contact OCDD to have the application sent to the adult. In some cases, depending on the ability of the adult and caregiver, the EPS Specialist will need to take the forms to the adult, assist in filling them out and return the forms to OCDD.

D. Documenting the Service Plan

On cases where a caregiver and/or adult are to be responsible for completion of tasks for part of the service plan, complete a Service Plan Form. Ask the caregiver and/or adult to sign the form. The EPS Specialist is to sign the form. It can be either handwritten or typed and a copy is to be provided to the adult and/or caregiver. A copy of the form is included in the forms appendix of this manual.

II. PURCHASING SERVICES

At the beginning of the investigation or during the initial face to face visit, the EPS Specialist may discover that an adult may not have food in the home, is in need of medication, does not have adequate/appropriate clothing for the weather, has no water, gas, or electricity in extreme weather and does not have the financial means or other resources to purchase such needed services. When the adult would be at risk of harm without these services and the EPS Specialist is unsuccessful in obtaining services for the adult through the above sources, the following steps shall be taken:

A. EPS Specialist shall notify the supervisor of the situation and of the specific services/items needed, as well as attempts to secure other assistance and of the long range plan to address these service needs.

B. The supervisor shall review the information and either approve or deny.

C. If approved, an itemized list of expenditures, a receipt, and a letter justifying the purchase will be sent to the supervisor/designee.

   The EPS Specialist shall be authorized to purchase items to include, but not necessarily be limited to:

   1. Medication
   2. Food
   3. Clothing
   4. Toiletries
   5. Linen

6. Ice
7. Heater
8. Fan

D. The purchase of service items is limited only to those adults in the most severe need, and must not be on an ongoing basis. The adult's service plan will address the adult's lack of essentials and how they will be provided.

E. The EPS Specialist shall document on the appropriate form and in the case activity notes, item(s) purchased, date, and the name of the adult for whom services or items were purchased.

F. The EPS Specialist may request financial services from vendors through the ARC of Baton Rouge. EPS has established a Crisis Fund to assist respective EPS adults with the purchase of needed services. The EPS Specialist shall review the request with the EPS Supervisor and complete the EPS Crisis Fund Request Form. The EPS Program Manager will review and approve these requests and forward them to the ARC of Baton Rouge for processing.

III. REMOVAL OF ADULT

The primary focus of the EPS Specialist should be to keep and protect the adult in his/her own home by removing the threat of danger from the home (persons, situations or environmental factors) or providing services in the home to prevent the need for removal. If removal is warranted, the EPS Specialist must explore the least restrictive setting available that will provide the adult with needed care, treatment and services sufficient to protect the adult from harm, and allow the adult to function as independently as possible. This removal/placement should be as short term as possible, while steps are being taken to remove the source of harm from the adult's home (if possible).

The EPS Specialist shall not remove the adult from his/her own home/living environment without first consulting with their Supervisor. The following sections provide a guide with criteria to consider prior to affecting any emergency removal.

A. Criteria for Decisions of Emergency Removal

1. The primary criteria for consideration of emergency removal is an immediate, clear, and substantial danger to the adult. It is important that the agency can prove the existence of the alleged danger, or at least, adequately explain the risk which prompted the decision to remove the adult.

2. The EPS Specialist's initial assessment must determine that the situation is at high risk for further abuse/neglect. Another important variable is the caregiver's response to the Agency's proposed services. If the caregiver appears genuinely concerned and willing to participate in the plan for services, then the need for

emergency removal may be alleviated. On the other hand, reluctance to participate by the caregiver, or previous failures to follow through on needed changes, can increase the need for removal.

3. Removing the adult from the home should be the last resort. The first attempt should be to remove the threat of danger from the home. If the accused is in the home, the EPS Specialist should try to get the person/persons to leave voluntarily while the investigation is being conducted. If the person is willing to leave, the EPS Specialist needs to make sure the adult's needs will continue to be met in the accused's absence.

   a. If the accused is not willing to leave, the EPS Specialist shall attempt to arrange for the adult's protection in the home, including using court intervention to remove the accused if warranted. The emphasis must be on assuring the protection of the adult.

   b. If the adult's safety in the home cannot be guaranteed, the next step shall be contacting other relatives or friends to take the adult into their home.

   c. If an alternative placement with family or friends is available, the EPS Specialist must assess the placement by interviewing the proposed caregiver, visiting the home and interviewing others who live there to determine the appropriateness of the placement.

4. Some specific situations for which emergency removals should be considered are:

   a. The adult requires immediate medical or behavioral health treatment which the caregiver/accused refuses or is unable to obtain.

   b. Abandonment of the adult by the caregiver/ accused and the adult is incapable of providing their own care.

   c. The adult's physical or mental condition renders the adult incapable of self protection and self-care, or for some reason, characteristics or conditions are likely to provoke further abuse, neglect and/or exploitation.

   d. The accused/caregiver's disciplinary techniques are bizarre, or ritualistic, and the caregiver has inflicted severe pain upon the adult, or is systematically inappropriate in response to the adult's behavior.

   e. The adult expresses fear and reluctance to remain with the caregiver/accused.

f. The caregiver/accused expresses concern about ability to control the abusive/negligent behavior; is unwilling to change; or, is unable to change because of emotional/mental impairment or substance abuse.

g. There is no caregiver available to provide care for an adult in need of supervision/care.

h. The physical condition of the home poses an immediate and substantial health and/or safety threat to the adult.

i. There is chronic exploitation/neglect/ self-neglect situations involving failure to thrive or malnutrition and/or starvation.

j. There is chronic neglect/exploitation; or, a recent crisis or recent deterioration in the living environment resulting in a dangerous situation.

k. There is sexual/physical abuse, the accused is in the home and is not willing to leave, and the caregiver is unable or unwilling to provide adequate protection.

5. If the EPS Specialist and the supervisor determine that only emergency removal will ensure the adult's safety, every effort shall be made to notify and consult with the EPS Program Manager or EPS Director before the adult is removed.

6. If emergency removal is indicated, the EPS Specialist should make every possible attempt to obtain and document the following:

   a. Name, age, birth date, personal financial resources, medical/physical condition (including medications taken), social security #, Medicaid #, and functioning level.

   b. Placements available (placements with relatives, if applicable including an assessment of the relative's background and reliability as a caregiver).

   c. Assessment of the adult's capacity to give informed consent.

   c. Whether available placements will meet the adult's needs, are in close proximity, and provide the least restrictive setting available.

7. The role of the EPS Specialist during the actual emergency removal shall include the following:

a. Arranging for medical care, if there is an emergency or life threatening situation.

If a life threatening or emergency situation exists, attention must first be given to the emergency medical needs of the adult (i.e., wounds, bruises, sores, burns, infections, severe illness, complications of disease, etc.) and the need for treatment/medication to prevent complications and/or save the person's life. Options include calling emergency medical services or having the person transferred to his/her physician or hospital emergency room. If the adult has the capacity to consent to medical treatment, consideration should be given to the person's wishes.

b. Determining the specific reasons which warrant emergency removal.

c. Obtaining consent (verbal and/or written) from the adult being removed in situations where the adult is capable of giving informed consent.

d. Initiating supervisory contact to determine steps to be taken when the adult is not capable of giving informed consent. See Chapter XII, Legal Intervention.

e. Preparing the adult for removal from their living environment and supporting the adult emotionally. (May assist them in obtaining or bringing clothing and other needed items, and explaining to the adult what the adult can expect to happen next.) In addition, support for the adult may be obtained from other sources such as case manager, case worker, therapist, etc.

f. Arrange/facilitate initial services to the adult, while in the new living environment.

B. Emergency Voluntary Removal

When the adult in need of protection is non-interdicted and has the capacity to consent to removal, permission for voluntary removal must first be obtained from the adult. This permission should be obtained in writing. If the EPS Specialist is unable to obtain permission in writing from the adult (or the adult is unable to write), attempts should be made to get a written statement from a witness who can verify that the adult gave his/her permission. Other persons responsible for the adult's care in the home (i.e. relatives, friends, payee, etc.) should be notified of the adult's decision to leave, as long as this notification does not place the adult at immediate risk of harm. This notification may be done via telephone in cases where the adult was not at home during the interview and does not want to return to the home at all.

When the adult in need of removal is interdicted (to the extent that he/she cannot make decisions in his/her own best interest regarding health care, food, clothing, shelter, safety, etc., See Chapter II, Definitions), permission for removal must first be obtained from the curator/curatrix. Permission is required whether or not the curator/curatrix lives in the same home as the adult in need of protection. Permission for removal by the curator/curatrix should be obtained in writing (with signature). If the curator is the accused, emergency court action may be necessary before removing the adult.

Note: An adult may be partially interdicted, (See Chapter II, Definitions), needing help only with financial or other matters, and still be able to make decisions about where he/she wants to live. You should review and obtain a copy of the court order verifying authenticity and type of interdiction in order to determine the adult's legal status.

Note: When the adult has the capacity to consent and has given permission for voluntary removal and the caregiver, parent, relative, friend, etc. living in the adult's home has refused or resisted this removal contact the supervisor for directions on how to proceed. Help from local law enforcement may be needed. Also, see Chapter 12 in the EPS Policy and Procedure Manual on how to proceed with legal intervention.

C. Emergency Voluntary Removal of Adults with Behavioral Illness

An adult who has a behavioral illness is mentally ill and who has not been interdicted/adjudicated as incompetent is considered to be a competent major under the law. An adult with chronic behavioral illnesses may vacillate in their capacity to consent depending on the severity of their behavioral illness, external environmental stressors, the effects of alcohol or drug abuse, or the degree to which they follow their prescribed medication regimen. Generally, the adult's wishes regarding removal must be followed. However, if the EPS Specialist has doubts about the adult's current capacity or believes he/she may be a danger to self, others, or gravely disabled (after discussion with and observation of the adult), medical and/or behavioral health evaluations or assessments should be sought (i.e., mental health center, mobile crisis team, coroner's evaluation, the adult's own physician or psychiatrist, hospital emergency room). Refer to Chapter XII, Legal Intervention for more on obtaining an evaluation when the adult does not or cannot consent.

D. Emergency Involuntary Removal

Before proceeding with emergency involuntary removal of an adult, the EPS Specialist must assess that the following criteria have been met:

1. The adult is at immediate and present risk of substantial harm or from abuse, neglect or self-neglect in his/her current living environment.

2. The EPS Specialist is unable to remove the threat of danger to the adult from the current living environment and/or is unable to provide services in the current setting in order to protect the adult from harm.

3. No other person authorized by law or by court order (curator/curatrix) to give consent for the adult is available or willing to arrange for protective services in the current living environment or is available or willing to agree to removal and the adult refuses removal.

4. The adult lacks the capacity to consent and refuses to leave.

5. The adult has been determined to be incompetent, homicidal, suicidal, or gravely disabled and refuses to leave. (See Section on Emergency Voluntary Removal for directions on how to arrive at these determinations.)

E. Emergency Involuntary Removal of Adults with Developmental Disabilities

An adult who has a developmental disability (DD) and who meets the aforementioned criteria will require legal intervention prior to removal. Contact the supervisor for directions on how to proceed. Adults with DD may be involuntarily removed via an ex-parte court order by EPS or the District Attorney via LA R.S. 15:1501, et seq. for 15 days but may be renewed one time for 15 days. Long term placement may be ordered by the court at the hearing on the ex parte order. Additionally, an adult with DD may be involuntarily committed to LDH custody via LA R.S. 28:404 or may be interdicted via Civil Code Articles 389 through 426. *Any* of these actions will require submission of affidavits, petitions, and a signed court order prior to executing any removal. See Chapter XII, Legal Intervention.

F. Emergency Removal of Adults with Behavioral Illness

A non-consenting adult who has a behavioral illness and who meets the aforementioned criteria will require evaluation and commitment in accordance with the provisions of the Mental Health Law, LA R.S. 28:1 et seq. Adults with Behavioral illness may be admitted to a mental health treatment facility only under the provision of LA R.S. 28:1 et seq. Emergency removal of behavioral health adults to other locations for purposes other than treatment may be done under the EPS law. Refer to Chapter XII, Legal Intervention for information on initiating proceedings under the Mental Health Law.

G. Emergency Removal of Adults with Physical Disabilities

If an adult is physically disabled and it has been definitively determined that he/she has capacity to make decisions, any refusal of protective services or other services must be respected. However, the EPS Specialist should attempt to explain to the adult, how services might benefit the person in their home. Also, the EPS Specialist should obtain written, signed documentation of the adult's refusal. If the adult is unable to write, attempts should be made to get a written statement from a witness who can verify the adult's refusal.

IV. CASE MONITORING

In some cases the service plan may require the EPS Specialist continue to work with the adult after the case is officially closed. These are typically high-risk adults whose cases are never quite stabilized or who generate frequent repeat reports. As a part of the service plan this case would be placed on monitoring status. The procedures for case monitoring are outlined below.

A. Case monitoring shall include, but not be limited to, the following:

1. Monitoring the adult's situation and level of risk.

2. Following up to ensure proper implementation of service plans, referrals and that achieved results are satisfactory .

3. Modifying service plans as the adult's situation and level of risk change.

4. Evaluating new information reported regarding the adult.

B. Cases that may be considered for monitoring status include, but are not limited to:

1. Cases involving behaviorally ill adults who may be at continued risk of harm due to a history of non-compliance with treatment (i.e., taking medications or making appointments) . Monitoring status should be used only if alternatives such as mental health rehabilitation or family support are not available.

2. Cases where services or placements have been applied for but are not expected to be obtained in the near future. Examples would include cases where no placement is readily available, or where there is a waiting list for services.

3. Cases where the needed services are not available. Examples include cases where a service is not offered in that region or where an adult is not eligible for a particular service.

4. Cases involving legal actions such as judicial commitments or ex parte orders that require follow up beyond the normal case closure deadline.

5. Any other case where the EPS Specialist and/or the supervisor have reason to believe that monitoring by EPS is a necessary part of the service plan.

C. Requirements for cases on monitoring status:

1. To place a case on monitoring status, an EPS Specialist shall notify his/her supervisor of the situation and explain the need for monitoring. After reviewing a case, the supervisor may confer with the EPS Specialist to place a case on monitoring status. Such cases will be closed in the data system. The supervisor is responsible for marking the case as monitored and activating the Follow Up case note (moving that case note) in the data system. Monitoring is to be noted in the service plan.

2. The EPS Specialist shall make follow up visits to the adult at least once per quarter, or more often if so specified in the service plan. If an adult is not home during a scheduled visit, the EPS Specialist shall make additional attempts as soon as possible thereafter until the adult is seen.

3. The EPS Specialist, with the adult's consent (provided the adult has capacity to consent), shall make phone contact as needed with other parties having knowledge of the adult's situation (e.g., family, neighbors, home health, other providers).

4. Information obtained by phone or through visits with the adult shall be recorded in the follow-up section of the case record.

5. If the adult's situation changes, so that the EPS Specialist feels monitoring is no longer needed, the EPS Specialist shall notify their supervisor, document the change in the follow-up section, and obtain the supervisor's approval to discontinue monitoring. The supervisor will be responsible for contacting the Intake Supervisor/ EPS database Administrator to remove the case from monitoring status.

V. ADULT REFUSES SERVICES

While any adult may refuse services, adults who lack capacity to consent and are at serious risk of harm must be protected even if legal intervention is required. (Refer to Chapter VIII for discussion on capacity). The adult who has capacity and refuses services shall be asked to sign a Service Refusal Form listing the services offered to the adult. If the adult refuses to sign the form, the EPS Specialist shall write at the bottom of the form, "the adult refused services" and then sign and date the form. A copy of the form is to be given to the adult. The Service Refusal form is included in the forms appendix.

XI. DOCUMENTATION

Protective Services for the elderly with disabilities consists of a number of procedures and services necessary to protect those persons from abuse, neglect, exploitation and extortion. Complete, concise, accurate and up to date documentation is necessary in order to effectively preserve information about the activities of the Agency, support legal interventions, and comply with legal requirements. Additionally, documentation provides a source of data to be used for agency planning, identifying systemic problems, monitoring staff performance and creating a safety net for staff.

I. DOCUMENTATION TIMELINES

A. Initial Entries

Policy requires that cases be documented as the case is worked. The first data entry is to be entered into the electronic case record no later than five working days after the deadline for first contact as indicated by the priority level assigned to the case. For example, the deadline for documenting on a priority one case is **no later than** twenty-four hours plus five working days from the case accepted date. These initial entries should document the following, at a minimum:

1. efforts made to contact the reporter, the client, and other persons; **and**
2. the face-to-face attempt date; **and**
3. any other efforts made on the case and any results (for example, the risk assessment score, capacity, etc.).

This documentation must occur even if the initial face-to-face is not successful. The record must be updated again no later than the close of the third business day after the face-to-face is made.

B. Updates

After the initial case entry is made, updates to the assessment, service plan, findings, and continued activity entries are to be entered on an ongoing basis until the case is closed. At a minimum, the first update is to be made no later than 35 days after the case accepted date. It must include the following:

1. the investigation completion date and the findings (or if the investigation is not complete an explanation as to why); **and**
2. the initial assessment narrative addressing allegations, capacity of the client and level of risk; **and**
3. the initial risk assessment score
4. if the case finding is substantiated or unsubstantiated with concerns, the service plan narrative shall also be entered (or explanation of why one is not needed or in place); and

5. up to date activity entries.

This entry should essentially be the first part of the final report. It can be modified as necessary as new information becomes available during the course of the case. It must communicate clearly the specialist's initial assessment, whether or not protective services are needed, and if so, what has been done to address the need.

Subsequent entries are required no later than every 30 days thereafter until the case is closed. In other words, entries are due at a minimum on the 35th, 65th, 95th days, etc. These entries must update the activity section and make any additions or corrections to the other sections of the report, based on what has taken place on the case.

When a case is completed, all the necessary documentation shall be entered and the case staffed with the supervisor before submission. Cases not closed by the 120th day shall have the reason for extension added to the activity section and be submitted for review. Before submitting the case for final review, spelling and grammar must be checked.

When cases are returned to the EPS Specialist for further action, the Supervisor will document the electronic record and notify the Specialist by e-mail the same day. The specialist is then responsible for correcting the case material and notifying the Supervisor no later than 21 calendar days after the case is returned.

II. DOCUMENTATION GUIDELINES

The EPS Specialist documents the investigation findings and service planning activities in the EPS database in an accurate, concise and timely manner.

As soon as possible after investigation, assessment and service planning activities and in accordance with the timelines listed above, the EPS Specialist documents his or her findings in the EPS database under the appropriate sections of the electronic case file. The electronic case file contains tabs for the accused, investigation and case notes. The case note section will contain sections for the description, follow-up, staff notes, activity and narrative. Each case shall be documented in the following fashion:

A. Narrative

The narrative section addresses six areas explicitly: summary of findings, allegations, capacity, level of risk, service plan and outcome. Each area shall be labeled and includes only information pertinent to that area. The EPS Specialist may reference other parts of the case file to make an entry more concise (but does not reference other related cases). When a client has multiple cases open at one time, parts of other case files may be cut and pasted into a record but those entries must be edited to delete information not pertinent to the record into which they are being pasted. Information in entries under the activity section should not be copied and pasted word for word to the narrative but rather, the narrative should be a summary of the pertinent information.

1. Summary of Findings

The summary of findings includes a comprehensive assessment of the client's situation. This includes the client's environment, mental status, physical condition, finances and social interactions. The assessment contains enough information to a give a basic profile of the client with special detail to those areas related to the allegations.

2. Allegation

Each allegation or problem is addressed separately. The discussion includes a presentation of all pertinent evidence discovered during the investigation related to the allegation and the process by which the EPS Specialist arrived at his or her conclusion regarding that allegation. (See "Formulating the Investigative Conclusion"). The facts of the comprehensive assessment of the client's situation and the discussion of the allegations are documented in separate paragraphs but may be cross referenced.

3. Capacity

The EPS Specialist assesses the client's capacity as part of the overall assessment of mental status but documents the findings under the heading CAPACITY to make this important information easily accessible and clear. The capacity assessment is based on the EPS Specialist's observations, collateral evidence from interviews, results of professional evaluations and the client's specific answers to capacity related questions. Documentation related to capacity always includes the questions asked and the client's answers and information about the client's understanding of the allegations and the consequences of action or inaction related to those allegations or other serious problems discovered in the course of the investigation. **A GENERAL STATEMENT THAT THE CLIENT HAS OR LACKS CAPACITY IS NOT ADEQUATE DOCUMENTATION OF CAPACITY.** (See Chapter VIII, Capacity)

4. Level of Risk

The assessment section concludes with a discussion of level of risk. Under the heading "level of risk" the EPS Specialist discusses the overall level of risk of harm to the client noted during the initial face to face visit. When the initial face to face occurs outside the home, it may be necessary to visit the client's home as well, if the case contains allegations related to the client's environment. Ratings of risk are discussed as low, intermediate or high rather than as the numerical score which is entered on the Investigation page of the case record. If the numerical risk score does not correspond with the descriptive score because it is skewed by very high or low scores for certain factors, the EPS Specialist explains the discrepancy.

5. Protective Service Plan

This section shall document both the actions planned to resolve the client's problems and the results of service planning. The EPS specialist lists and numbers each problem or risk factor, the action planned to address it, the person who will perform the action, the expected completion date, the specific result expected, and whether it was completed. If the task has already been completed then the EPS Specialist would also document the date completed. For a task which is of an on-going nature, the EPS Specialist would

show on-going. Include **ALL** actions taken to remedy the problem(s), whether they are done during the investigation/assessment or later. Be sure to include any crisis intervention services arranged or provided. This section also contains the minimal narrative information that is necessary to understand the service planning process. For example, if the client could not participate in service planning it would be noted here. All refusals of services are also explained in this section.

Each service plan problem and action step must contain a corresponding case activity log identifying the date and time of contact, the person/organization contacted, and the manner of contact.

The case activity log documentation should have enough information when making the referral for services, to prevent further abuse, neglect, exploitation or extortion. Documentation includes such things as: "council on aging contacted to refer client for home delivered meals to ensure client has a meal available," "Referral made to client's physician to add Physical therapy order to the home health services already in the home to decrease client's fall risk."

On cases where the finding is Substantiated or Unsubstantiated with concerns and a service plan is not required give an explanation (e.g., cases in which clients have died prior to the case closure, cases in which clients refuse services).

6. Outcome

The outcome is documentation of the status of the client's general situation and the status of problems at the point of closure. The primary focus is to be the overall outcome of EPS intervention.

For substantiated allegations, it shall include references to the results of actions in the service plan and how they impacted the problems identified in the assessment process. The primary focus is to be the overall outcome of EPS intervention. It should also address the client's current level of risk, attempts at risk reduction and if none occurred, why. If the client has been placed, the type of placement, the name and location of the facility and verification of the client's placement are included.

It shall also state which allegations are unsubstantiated or unsubstantiated with concerns. When cases are substantiated or unsubstantiated with concerns and there is no service plan, the EPS Specialist documents why in this section. When a case is unsubstantiated and referrals are made, this section shall identify those referrals.

B. Activity

This section is used for documenting all contacts, consultations with supervisors, and other entries that are part of the case process. Each entry shall include the date of the contact, the contact type, the name of the person contacted, the purpose of the contact and a concise, complete description of the event. For major entries, like the face to face and other contacts, that are pertinent to the assessment and investigation process, the

EPS Specialist documents the content of the contact in the activity section with information relevant to the assessment and investigation in the narrative section. When complete, the entries under the activity section should give a clear picture of the how the case progressed from beginning to end. The final activity entry in every case shall address case closure. This entry documents our discussion with the client regarding case closure or if informing the client of case closure was not possible, the circumstances of the closure.

C. Other Information

Before submitting the final case for approval, the Specialist must check to make sure that all the identifying information in the record is correct. Names, addresses, and phone numbers of the client, accused, caretaker and other collateral contacts are to be current; diagnoses, disabling conditions and benefits must be correct and complete, etc. All interviews include who was present, where the interview took place and what specific information was obtained. All entries are to be reviewed for clarity, accuracy, spelling, and grammar.

E. Other Information

Before submitting the final case for approval, the Specialist must check to make sure that all the identifying information in the record is correct. Names, addresses, and phone numbers of the client, accused, caretaker and other collateral contacts are to be current; diagnoses, disabling conditions and benefits must be correct and complete, etc. All interviews include who was present, where the interview took place and what specific information was obtained. All entries are to be reviewed for clarity, accuracy, spelling, and grammar.

XII. LEGAL INTERVENTION

The activities of the Eldrerly Protective Services Program are authorized by LA R.S. 15:1501-15:1511. This also authorizes the agency to use legal interventions when necessary to carry out the responsibilities of the EPS Program. Section 15:1507 outlines the various legal interventions available to the agency. Section 15:1502 B authorizes only the least possible restriction on the exercise of personal and civil rights consistent with the person's need for services and requires that due process be followed in imposing such restrictions.

I. INVESTIGATIONS REQUIRING LEGAL INTERVENTION

The decision to initiate any type of legal action, including but not limited to orders for protective custody, judicial commitments, interdictions, and *ex parte* orders shall be made only after the EPS Specialist confers with a supervisor. The EPS Specialist must be prepared to provide a detailed description of the facts which led to the conclusion that legal intervention is necessary and present these facts to the supervisor. If, after a review of the facts, a supervisor concurs that legal intervention is necessary to protect the victim, the Specialist may proceed with the intervention. In cases requiring filing of legal documents by EPS, the Specialist and/or supervisor shall consult with the EPS Program Manager and then GOEA General Counsel for additional guidance and assistance. The EPS Specialist and supervisor must assure that accurate and relevant facts are presented to the attorney. The supervisor must review any legal documents before they are filed. The EPS Program Manager shall be notified prior to the filing of any legal documents pursuant to the APS statute, and copies of all legal documents shall be forwarded to GOEA General Counsel. This includes orders or judgments issued after both initial and follow-up hearings.

A. Orders to Enter the Home or Obtain Access to the Client

Except in cases where there is known or perceived danger to the EPS Specialist, situations where the Specialist is refused or denied access to the client, the home, or another location where an alleged incident of abuse took place (whether by the client or someone else) should be handled by attempting to reasonably explain the purpose of EPS involvement. This includes informing the person denying access of EPS and the Specialist's role, responsibility, and authority under LA R.S. 15:1507. The EPS Specialist should emphasize that a face to face interview with the alleged victim, etc. is required by law. The Specialist may also point out that he/she may be able to refer the client to other social services within the community. If access continues to be denied following a reasonable attempt, the EPS Specialist shall request assistance from law enforcement. *In cases where there is known or perceived danger, law enforcement assistance shall be requested initially.* If law enforcement fails to cooperate or if access is still denied, intervention by the court must be attempted.

The EPS Specialist shall notify the supervisor of the situation as noted above. The Specialist shall participate in preparing an affidavit outlining the facts known at that point and documenting attempts to access the client or location. In consultation with the Agency Attorney, an Order to Enter (see the forms appendix) shall be prepared and presented to the court. If the court approves the order, the Specialist shall then obtain law enforcement assistance in serving and enforcing the order.

B. Non Emergency Civil Interventions Under LA R.S. 15:1507

The EPS law authorizes the district attorney or EPS to initiate civil interventions in situations where it appears the client has been abused, neglected, or exploited and where the problem cannot be remedied without legal intervention. In such cases the EPS Specialist shall follow the steps outlined above to obtain supervisory approval and assistance from the GOEA General Counsel. The supervisor and GOEA General Counsel will determine whether the action is more appropriately initiated by EPS or referred to the district attorney. A petition and order, accompanied, by an affidavit, must be prepared and filed (or the necessary information provided to the district attorney as outlined in LA R.S. 15:1507 (F).

Specific interventions that may be requested include 1) an order for mandatory counseling for the parties involved to prevent further abuse, 2) an injunction against the parties contributing to the abuse to "cease and desist", 3) an injunction against any party interfering with the provision of protective services, 4) an order to provide protective services, and 5) an order to have the client receive medical, psychiatric, or psychological evaluations to determine capacity and least restrictive intervention. All these orders may be used as remedies (i.e., part of an intervention plan). The order to have the client evaluated may also be used where the client's capacity to consent is questionable, especially if the client is at risk and is refusing services. In any case where a client is at serious risk of harm and refusing services and where capacity is questionable, seeking such an order must be discussed with the supervisor before the case is closed.

Orders to provide protective services require that the client lack capacity and be suffering harm (or likely to suffer harm) due to abuse if protective services are not provided, and no person with legal authority to consent to services is available or willing to do so. Such orders must specify the services or protections needed, which may include a variety of services (see R.S. 15:1508 (5)). Such orders are effective for 180 days, and may be renewed for an additional 180 days and annually thereafter upon showing the court that continuation is needed to prevent harm to the client.

Hearings on the above orders must be held within 20 days of the filing of the petition.

Cases where long term orders are in place shall be kept on monitoring status.

C. *Ex Parte* Orders

If the client is believed to be at immediate and present risk of substantial harm or deterioration from abuse, neglect, or self-neglect and lacks the capacity to consent, or with the consent of an Elderly who has capacity, an ex parte order to provide emergency protective services may be sought. Supervisory and legal consultation is required as noted above. A petition, affidavit, and order must be prepared and filed. Ex parte orders and orders for protective services may ask the same types of services or remedies. The ex parte order is good for fifteen days, but may be renewed for an additional fifteen days. The hearing must be held before the expiration of the order, but no sooner than fifteen days after the order is signed. At the hearing the court may issue an order for protective services with the time frames noted in the previous section.

If the circumstances are such that there is no time to file a petition, the facts supporting an ex parte order may be relayed to the court orally or telephonically and the court may issue an oral order. Alternatively, the court may issue a written order based on the oral statements. In any case, a written petition, affidavit, etc. must be filed by the close of the next business day.

Supervisory approval must be obtained before seeking a verbal order. The contact with the court must be thoroughly documented. Since law enforcement must execute the order, it is strongly advised that an officer be present and/or included in the discussion with the court.

D. Service of Court Orders

The Code of Civil Procedure provides that the Sheriff is the executing officer for the district court (where EPS orders are ordinarily obtained) and shall serve all citations, summons, etc. and execute all writs, orders and judgments. The marshal or constable serves this function for parish and city courts. The Code also provides that, if the sheriff has authorized them to do so, the constable or marshal can carry out these functions for the district court within the territorial boundaries of the lower court.

When obtaining ex parte orders specialists hand carry orders through the system. Once a signed order is obtained from the court, the specialist should contact the Sheriff's office for assistance in having the order executed. If the Sheriff has authorized them to do so as noted above, the matter may be referred to a constable or marshal. If for any reason the order was obtained in a parish or city court, the specialist should contact the constable or marshal first for assistance in executing the order. In no case should specialists attempt to execute an order on their own.

If the order involves removing a client from the home, or picking a client up for evaluation, the specialist must be present when the order is executed. Specialists also need to ensure that any necessary service providers are on hand to address the

client's needs. If the order is simply a restraining order or other order that does not involve removal or custody, it is not mandatory that the specialist be present. However, in all cases the specialist must ensure that the client understands what is taking place and that any needed protective measures or services are in place.

E. Interdictions

Elderly Protective Services may seek an Order of Interdiction provided that;

1. an investigation for abuse, neglect, exploitation or extortion has been substantiated;
2. legal intervention has been determined by Elderly Protective Services to be necessary to prevent further abuse, neglect, exploitation or extortion of the Elderly; after other less restrictive options have been explored, including, but not limited to:
    a. Community Services (social, medical, financial and/or legal)
    b. Family Involvement
    c. Representative Payee
    d. Emergency Protective Services Order
    e. Judicial Commitment by a treating facility

When an interdiction is required to protect the endangered adult, Elderly Protective Services shall attempt to contact family or other interested party (as appropriate) that may be able to initiate an interdiction.

Elderly Protective Services does not accept cases for investigation or initiate interdictions for Elderly solely because a person lacks capacity to consent to medical treatment and has no legally authorized person to do so on their behalf. Such cases should be handled pursuant to the state Medical Consent Law.
Funding for Louisiana Guardianship Services by the Governor's Office of Elderly Affairs is solely for the purposes of providing curator or representative payee services for victims of abuse referred by Elderly Protective Services following substantiated cases of abuse.

F. Other Legal Interventions

Other legal interventions may be required as part of the intervention plan to remedy abuse. This includes, but is not limited to, interdiction, removal of a curator or tutor, judicial commitment, and order for protective custody (OPC). Supervisory approval is required prior to initiating any of these interventions. Consultation with GOEA General Counsel is required prior to initiating any action other than an OPC.

Admission to a behavioral health treatment facility must always be under the provisions of the mental health law (R.S. 28.1 et seq) and not under the APS law. An OPC shall not be sought unless the Specialist has personally seen the client and believes, based

on assessment and other available facts, that the client meets the criteria. If a reporter or family member wants the client OPC'ed but the Specialist does not have evidence that the client meets the criteria, the Specialist may assist the reporter or family member in contacting the coroner, but shall not sign the OPC affidavit.

G. Due Process Rights of Clients

EPS clients have the right not to be declared incompetent or committed to a mental institution without access to due process of law. In any proceeding initiated under the APS law the client is entitled to be represented by an attorney. If the client does not have or cannot afford an attorney one must be appointed by the court.

II. GUIDELINES FOR CASES INVOLVING OTHER LEGAL ISSUES

A. Guidelines for Cases Involving Interdiction:

1. Ask to see letters of curatorship and/or a copy of the judgment. These should be issued by a court of competent jurisdiction in Louisiana. If the curator cannot produce them, check with your supervisor. Once you have the records, establish whether the interdiction is full or limited. If it is limited, determine what rights the client has lost.

2. If the curator is not the accused in the case, you will need to work with or through the curator. The extent of the curator's involvement will depend upon whether the interdiction is limited or full. For example, the curator, not the client, may need to sign release of information or other forms.

3. If a curator is the accused, he/she cannot deny EPS the right to conduct an investigation. If someone attempts to do so, consult your supervisor.

4. If a curator is substantiated as a perpetrator, he/she may need to be removed depending upon the severity of the abuse, neglect, or exploitation. If protection is needed on an emergency basis, EPS may take legal action.

B. GUIDELINES FOR LOUISIANA GUARDIANSHIP SERVICES:

GOEA has a signed Memo of Understanding (MOU) with Louisiana Guardianship Services, Inc. (LGSI) to purchase assistance with money management or for those in need of guardianship services. During an EPS investigation if the findings reveal that a disabled adult needs LGSI assistance, the EPS Investigator will discuss the case with the EPS Supervisor and subsequently refer and discuss the case with the Program Manager for review of eligibility and approval. All LGSI referral cases will be reviewed for compliance with internal policies and procedures. All approved cases will be submitted on the LGSI Referral Form located in Appendix C.

C. GUIDELINES FOR USING THE MENTAL HEALTH LAW:

1. Coroner's offices operate differently across the state. In most cases they will not send out someone to evaluate a client in the field. Instead, someone must go the coroner's office and sign papers to start an OPC. Specialists should not sign *unless* they have seen the client and determined through their assessment and observation that the client is at serious risk of harm if not examined or treated. An OPC should not be initiated solely based on the statement of a reporter or collateral. If such a person insists an OPC is needed and the Specialist does not agree, the person has the right to initiate the OPC on their own.

2. In a few parishes, coroners do not issue OPCs. Obtaining one will require appearing before a judge.

3. When obtaining an OPC it is important to consider what facility the client will be sent to and who will see them. For example, all other things being equal, it is preferable for the client to see a psychiatrist at a behavioral health facility than an ER physician at a hospital. The specialist may have no control of this, but where possible, let the facility and/or doctor know the client is coming and give them information about the situation or case. Information regarding the history and recent behavior may assist the evaluator in assessing the client's condition when used in combination with the client's presenting behavior.

D. Guidelines for using the Domestic Abuse Law

The Domestic Abuse Law provides a civil remedy for domestic violence which provides the victim immediate and accessible protection. This is applicable in cases where the perpetrator is a parent, child, sibling, grandchild or other member of the household.

E. Guidelines for Cases Involving Powers of Attorney

Powers of attorney are frequently abused. When a caregiver or other person says they "got power of attorney over the client", this is/may be an area of concern.

Remember the client must have had capacity and must have understood what he/she was agreeing to. Powers of attorney given by clients whose capacity is questionable may indicate exploitation.

The specialist should always obtain a copy of the power of attorney in order to see exactly what powers it grants. Exceeding the authority of the power of attorney or using it for one's own gain may indicate exploitation. A client who has capacity may revoke a power of attorney. Like the granting of the power, this should be done in writing and copies should be sent to anyone (bank, doctor, etc.) who has a copy of the power of attorney. It is not absolutely necessary to have an attorney to complete this process,

however one can be obtained to assist the client through pro bono legal services if available.

XIII. CASE CLOSURE

When EPS clients are found to be in need of protective services, the case should be closed at the point that the situation is stabilized (or as stable as reasonably possible), the client is no longer at risk (or risk is reduced as much as reasonably possible), or the client who has capacity has refused further assistance. Case closure requires supervisory review and approval.

I. CASE CLOSURE GUIDELINES

Each step in the investigation process brings you closer to closing a case. Completing the assessment leads to a determination of the capacity of the client, the risks involved and the findings in the case. These findings will help determine the outcome codes and decide whether or not legal action is necessary. The goal of EPS is to complete the investigations within 30 days, and close cases within 120 days, or request an extension for additional investigation or service planning. EPS cases which require additional follow-up may be classified as needing monitoring. All of the activities necessary to investigate a case, make a finding with regard to the allegations, plan and arrange services are to be completed and documented before closure.

A. Requirements Prior to Case Closure

A case may not be closed until there has been a final staffing with the supervisor, case documentation is up to date, and the supervisor has approved closure. The supervisor shall check the electronic entry in the EPS database for completeness of investigation and services and completeness and accuracy of the data entry (see the EPS database manual for more information) before giving approval for closure using the event, Final Supervisory Review and Closure or other code as appropriate. Before an EPS case is closed the follow-up risk assessment must be completed, including a face-to-face assessment where warranted. The final staffing and notifications must be documented in the case activity log or in the events table.

B. Extensions

When a case requires ongoing casework beyond the established deadline, the supervisor may grant an extension. For cases requiring a Service Plan, a thirty (30) day extension will be automatically granted. Cases where the casework is complete but the documentation has not been finished will not be given extensions and will be considered past due after the established deadline has passed.

After the final staffing, the Specialist completes the entries in the database for findings and closure as agreed to in the staffing.

II. THE INVESTIGATIVE DECISION: FINDINGS CODES

A. EPS Cases

There are four findings codes used in cases:
Substantiated,
Unsubstantiated with concerns,
Unsubstantiated,
Non-Finding

Based on the investigative findings and assessment, a decision shall be made as follows:

1. **NEEDS PROTECTIVE SERVICES** - the investigation/assessment indicates that the situation and condition of the client warrants further action in the form of protective services intervention. This can be due to one of two findings:

    a. **SUBSTANTIATED** A/N/E/E. A review of the facts and a preponderance of the credible evidence shows that abuse, neglect and/or exploitation has occurred or is occurring and that the adult needs protective services to remedy or stop the maltreatment. If the decision is made that the adult needs protective services, one of three courses of action shall be followed:
        i. Client has capacity and consents - If the adult has the capacity to make an informed decision and agrees to accept services, a service plan will be developed, and service delivery initiated;
        ii. Client lacks capacity If the adult lacks the capacity to consent to receive services or capacity is questionable and there is a high risk of harm, there is no responsible caregiver available to assume responsibility for the adult, or the caregiver refuses protective services for the adult, short-term protective services may be initiated via an ex parte order or through petition of the District Attorney. A petition for protective services, interdiction, judicial commitment or Departmental custody may be filed to allow for more long range services; or
        iii. Client has capacity and refuses - If the adult has the capacity to consent but refuses to accept the protective services, the case will be reviewed carefully to determine if other alternatives exist which could be beneficial to the adult, and would be acceptable to him/her. A referral for such services will be made and documented in the case report. If there are no alternatives acceptable to the adult, the case will be closed.

    b. **UNSUBSTANTIATED WITH CONCERNS** RE: A/N/E/E - A review of the facts and a preponderance of the credible evidence is inconclusive as to whether abuse, neglect and/or exploitation has occurred or is occurring. However, there are sufficient risk factors for A/N/E/E present in the client's situation to cause concern that the client is at risk of harm from A/N/E/E even though the present allegation cannot be substantiated. Protective services are needed to reduce

the risk and/or prevent the situation from becoming worse. The same three options for intervention exist, except that legal intervention may be limited by the fact that the case cannot be substantiated. Situations involving clients who lack capacity or whose capacity is questionable and are believed to be at risk should be discussed with Central office to determine the appropriate course of action.

2. **UNSUBSTANTIATED** A review of the facts and a preponderance of the credible evidence in the investigation indicate that the alleged abuse, neglect, exploitation and/or extortion did not occur. No service plan is needed. However, referral(s) to appropriate services where indicated should be made and documented.

3. **NON-FINDING** - This finding is only appropriate when the investigation cannot be completed for one of the reasons listed below, the EPS Specialist has completed all procedures discussed below, and there is not enough information to determine a regular finding on the case. **Supervisory and EPS Program Manager approval must be obtained before a non-finding is used.**

Unable to Locate The Adult - The following conditions listed below ***must all*** be true before the case can be closed with a non-finding:

i. The adult could not be located at the address or location provided by the reporter; or the actual resident at the reported address had no resemblance to the subject of the report; and
ii. The reporter could not be contacted or could not provide an adequate address; and
iii. The EPS data file and other available database checks failed to provide an adequate address; and
iv. Neither the named adult's neighbors, nor relatives, nor City Directory/Directory Assistance, nor Post Office, nor law enforcement were able to provide information about the adult's whereabouts; and
v. Supervisory and EPS Central Office approval to discontinue efforts to locate the adult has been secured.

a. Deceased Adult - If an adult dies prior to or after an investigation has begun and the adult's death is unrelated to the allegations, or there is no reason to continue the investigation (no criminal acts are involved) and supervisory and EPS State Office approval has been secured, the case may be closed.

b. No Longer at Risk - The adult has been removed from danger prior to the intervention of Adultly Protective Services and is not in need of any services. No known criminal activity was involved and EPS Supervisory approval has been secured.

c. Does Not Meet Eligibility Criteria - The investigation is halted before a finding is reached as it is determined the adult does not meet the eligibility criteria and supervisory and EPS Supervisory approval has been secured.
Example: A person who has a disability diagnosis who is clearly able to advocate for and protect him/herself does not meet eligibility criteria.

III. CASE DISPOSITION – CLOSURE CODES

A. Closure Reasons

Upon completion of the investigation and implementation of the service plan the case shall be closed. Only one closure reason can be used on each incident and it must be appropriate to the finding. If there is a substantiated finding, it takes precedence over an unsubstantiated or non-finding and a closure reason for a substantiated finding must be used. If there is no substantiated finding and at least one unsubstantiated finding, then a closure reason for unsubstantiated findings must be used. If there are no substantiated or unsubstantiated findings, then a closure reason for non-findings must be used. The allowable closure codes for each of the findings are shown below:

If the finding is Substantiated, the allowable codes are:

1. **CASE STABILIZED, SERVICE PLAN COMPLETE** - The service plan has been developed and implemented. The adult is safe and/or maltreatment or risk have been stopped or reduced as much as possible.

2. **NO LONGER AT RISK** - The danger or risk to the adult has been removed without the need for development and implementation of a service plan or other protective services intervention. Client is not in need of any services.

3. **SERVICES REFUSED** - The adult refuses services and he/she is a competent major and has the capacity to make informed decisions.

4. **MOVED - CAN'T LOCATE** - The adult has moved and the EPS Specialist, after exhausting all avenues of inquiry, is unable to locate the adult.

5. **DECEASED-NO FURTHER ACTION NEEDED** - The adult died during the course of the case. Death does not appear to be due to maltreatment.

6. **DECEASED-OTHER ACTION TAKEN** - The adult died during the course of the case. There is reason to believe death may have been related to maltreatment and the case is being referred to law enforcement and/or the District Attorney.

If the finding is Unsubstantiated with Concerns, all codes listed under Substantiated may be used plus:

1. **SERVICES NEEDED-REFERRED TO ANOTHER AGENCY/PROGRAM** - The adult's situation can be improved with additional services. The adult was referred to other agencies for services.

If the finding is Unsubstantiated, the allowable codes are:

1. **SERVICES NEEDED-REFERRED TO ANOTHERAGENCY/PROGRAM** - Although there are no concerns re A/N/E/E, the adult's situation can be improved with additional services. The adult was referred to other agencies for services.

2. **SERVICES REFUSED** - The adult could benefit from services, but refuses services. He/she is a competent major and has the capacity to make informed decisions.

3. **DECEASED-NO FURTHER ACTION NEEDED** - The investigation is complete, the adult died and the allegation was unsubstantiated. Death does not appear to be due to maltreatment.

4. **NO SERVICES NEEDED** - The adult does not need services or is already receiving all the services he/she needs.

If there is a NON FINDING (See Section 3 under Investigative Decisions to determine when a non-finding can be used.) the allowable codes are:

1. **NO LONGER AT RISK** - The danger or risk to the adult has been removed without the need for development and implementation of a service plan or other protective services intervention. Client is not in need of any services.

2. **MOVED/UNABLE TO LOCATE** - The adult has moved and the EPS Specialist, after exhausting all avenues of inquiry, is unable to locate the adult.

3. **DECEASED/NO FURTHER ACTION NEEDED** - The adult died during the course of the case. Death does not appear to be due to maltreatment.

4. **DOES NOT MEET ELIGIBILITY CRITERIA** - The investigation or assessment is halted before a finding is reached as it is determined the adult does not meet the eligibility criteria.

IV. OUTCOME CODES

In addition to the closure code (reason for closure), each EPS case must have one or more outcome codes. The outcome code should describe the condition of the client at the time of case closure. With the exceptions noted below, any outcome code can be used with any finding. However, care should be taken that the finding, closure code, and outcome code are logically consistent. The exceptions are that "deceased" outcome can only be used with deceased reason for closure and "outcome undetermined" can only be used with these reasons for closure: "moved, can't locate" and "does not meet eligibility criteria".

A. Outcome codes for allegations of neglect or self neglect are:

1. **CLIENT AND/OR CAREGIVER PROVIDING FOR BASIC NEEDS** - The adult's basic needs are being met either through his/her own efforts or those of a caregiver or both. This may or may not be as a result of EPS intervention.

2. **CLIENT HAS FAMILY, FRIENDS, OTHERS PROVIDING SUPPORT AND ASSISTANCE** - The client has a support system that is providing for his/her needs. This may or may not be as a result of EPS intervention.

3. **CLIENT KNOWN TO SERVICE SYSTEM AND ALREADY RECEIVING SERVICES** - The client is already enrolled in services through LDH Program Offices or other resources and is already receiving needed services. This outcome may most often be used with unsubstantiated cases (i.e., caregiver neglect), but could also be used for a substantiated case. For example, the client could have been physically abused even though receiving all needed services.

4. **CLIENT'S RESOURCES AND ASSETS BEING MANAGED PROPERLY BY CLIENT OR COMPETENT OTHER** - This would primarily be used as an outcome for exploitation or extortion allegations. This may or may not be as a result of EPS intervention.

5. **CLIENT'S SITUATION SAFE** - The client is not/no longer at risk of harm. This could be used in cases where a perpetrator is removed, client is placed, etc. It could also be used for unsubstantiated cases where there was no evidence that the client was at risk in the first place.

6. **DECEASED** – The client died during the course of the case.

B. Outcome codes for allegations of physical, emotional, or sexual abuse.

7. **MALTREATMENT CONTINUES** - The case is substantiated and the A/N/E/E is ongoing. This should only be the case when a client who has capacity to consent refuses services. Otherwise, if maltreatment is ongoing, legal intervention should be explored. Consult with your supervisor prior to using this outcome code.

8. **MALTREATMENT REDUCED** - The case is substantiated and the extent of A/N/E/E and/or the risk of harm has been reduced, but not entirely eliminated. This is likely to frequently be the case, as it is often impossible to completely eliminate risk.

9. **MALTREATMENT STOPPED** - The case is substantiated and the A/N/E/E has been stopped.

C. Undetermined Outcomes

10. **UNDETERMINED** - This outcome should only be used in cases where the investigation/assessment was not completed, the client moved or could not be located, etc. This outcome would mainly be used with non findings.

V. LEGAL ACTION EVENTS

Any legal actions taken during the course of a case should be noted and must be entered in the Events table of the database. The following events are used:

A. PLACED IN LDH CUSTODY

Client placed in the custody of the Department pursuant to an ex parte or other court action (usually under the Developmental Disabilities Law).

B. CRIMINAL CHARGES FILED/ARREST MADE

Charges have been filed against the perpetrator and/or he/she has been arrested.

C. ORAL EX PARTE ODER ISSUED

A verbal order was obtained for protective services due to the seriousness of the situation. A verbal order must be followed by a written petition for protective services filed by the close of the following business day.

D. PETITION FOR EX PARTE PROTECTIVE SERVICES FILED

A petition for a protective order under La. R.S. 15:1511 has been filed with the District Court.

E. EX PARTE PROTECTIVE ORDER OBTAINED

A protective order (which may or may not include placing the client in custody) has been obtained under La. R.S. 15:1511 by the District Attorney or the GOEA General Counsel.

F. PETITION FOR PROTECTIVE SERVICES FILED (NOT EX PARTE)

A petition for a protective order under La. R.S. 15:1508 has been filed with the District Court.

G. ORDER FOR PROTECTIVE SERVICES OBTAINED

A protective order (which may or may not include placing the client in custody) has been obtained under La. R.S. 15:1508 by the District Attorney or the EPS Regional Attorney.

H. FIRST HEARING HELD ON PETITION

The 15 or 20 day hearing, as required by law, has been held on the petition for protective services.

I. FOLLOW UP HEARING HELD

A hearing has been held on the ORDER or JUDGMENT in accordance with the law.

J. NEXT HEARING DUE

Orders for protective services must be held every180 days (for the first 2 hearings after the 15 day hearing) and then annually. After the 15 day hearing is held, the Specialist should calculate the date the order will expire and enter that date with this event.

Note: The above two events (Follow up Hearing Held and Next Hearing Due) may be reused throughout the course of a court case. Since events can only be used once, however, this means that the Specialist must document the dates in the Activity or Follow-up sections of Case Notes prior to deleting them and re-entering them with new dates.

K. CASE DISMISSED/ORDER ALLOWED TO EXPIRE

The petition for protective services was dismissed by the Judge or an order for protective services already in place was allowed to expire because the client's situation has improved to such a degree that the protective services are no longer needed.

L. JUDICIAL COMMITMENT OBTAINED

The client has been judicially committed under the Mental Health law. It does not matter who initiated the commitment.

M. ORDER OF PROTECTIVE CUSTODY OBTAINED

The client was OPC'ed, CEC'ed, or PEC'ed for evaluation under the Mental Health Law. It does not matter who initiated the action.

N. CONSENT AGREEMENT ISSUED/SIGNED

An agreement on the protective services that will be provided to an EPS client has been reached without the need for a hearing. This agreement has been filed with the court.

O. INTERDICTION OBTAINED

A client has been deemed incapable of making decisions regarding his/her personal well-being and/or property by a court of law. It does not matter who initiated the action.

P. OTHER LEGAL ACTION

If any other legal action is taken. For example, the client obtained a restraining order under the Domestic Violence law, etc.

Q. REFERRED TO DISTRICT ATTORNEY

The case was referred to the District Attorney for either civil or criminal action.

R. REFERRED TO LAW ENFORCEMENT

The case was referred to law enforcement for investigation of possible criminal activity. This event must be entered in any case where the Specialist discovered possible criminal activity/abuse, referred the situation to law enforcement, **and** the Intake Unit has not already reported the situation to law enforcement. Intake will use the event, "Reported to Law Enforcement" when they make such referrals for physical and sexual abuse, as required by law.

S. REFERRED TO ATTORNEY GENERAL

The Attorney General should be notified of any consumer or Medicaid fraud against an EPS client discovered during an investigation.

VI. CASE MONITORING

On some cases the service plan may require that the Specialist continue to work with the client after the case is officially closed. See Chapter XI, Service Plan, for the criteria. Any cases in which the client is under some type of protective order at closure should also be placed on monitoring status. All further documentation regarding the client is to go in the Follow-Up section of the electronic case record. Cases on monitoring status are to be updated as often as the client's situation changes, but no less than quarterly. Cases are to be updated before the supervisor removes the case from monitoring status.

XIV. SUPERVISION

Supervisors in Elderly Protective Services have the responsibility of providing support and guidance to the Specialists in order to enable them to perform reliable and efficient work in assessing and protecting Elderlys with disabilities living in the community. When work performance is inadequate, supervisors have the responsibility to identify the problems causing the poor performance and take steps to correct it according to the guidelines in this chapter. Supervisors rely on their past experiences, training, knowledge of policy and consultation with management staff to be prepared to respond to Specialists' questions and to offer direction on case progress.

I. SUPERVISORY RESPONSIBILITIES

Supervisors are to review and manage the work of the EPS Specialists in the following areas.

A. Response Times

Assure that the EPS Specialist is responding within the time frames outlined in the priority system and conducting a face-to-face interview with the adult in need of protection. Also, assure that all pertinent data needed to address the situation is, to the degree possible, obtained by the EPS Specialist at each visit by assisting the EPS Specialist in formulating questions and determining what information will be necessary to a complete assessment/investigation. This is especially important in priority one cases and in repeat cases.

B. Emergency Services

Assist/intervene when the EPS Specialist is unable to arrange for emergency services/crisis intervention to protect the adult from further harm or when services needed by the adult are unavailable. If the EPS Specialist is unable to put services in place on the regional level, the supervisor contacts other agencies at the state office level to try to make necessary services available.

C. Advise

Review new case assignments as they are assigned. Staff cases with the assigned specialists prior to initial contact on cases where required by policy and on any other cases that appear particularly complex or sensitive. Specialists are to consult with their supervisors on all Priority one cases, repeat cases, cases referred to law enforcement at intake, cases involving unlicensed facilities and other complex cases. Supervisors are responsible for ensuring that these cases are discussed. They are to be available to the EPS Specialist during work and, as needed, after hours, to provide supervisory guidance, technical assistance, and direction in all aspects of conducting an investigation or assessment, determining the need for protective services, stabilizing the situation, protecting the client, linking services to client needs and developing a service plan. The case staffing done just prior to the Specialist submitting the case for

closure should be documented with the event, "Case staffed with Specialist". All other case consultations should be documented in the Staff Notes section of the electronic case record EPS database.

D. Legal Intervention

Assist the EPS Specialist when legal intervention is needed in order to protect the Elderly or to remove the Elderly to a safer living environment. Provide direction to the EPS Specialist when preparing court affidavits and/or facilitating appropriate placements in the least restrictive settings. Assist the GOEA Attorney or District Attorney facilitating legal intervention. Assure that copies of legal documents are filed in the permanent file of a case and that copies are provided to state office. Assist the EPS Specialist in tracking cases and preparing for court hearings by updating the attorney on the case and providing information regarding individuals/professionals who may have pertinent information to report to the court.

E. Review

Supervisors shall review all EPS cases submitted for closure by Specialists within 5 working days of notification of the submission. Document approval for case closure by entering the event, "Final Supervisory Review and Closure" after assuring that the following requirements are adhered to: appropriate investigative and/or assessment techniques are used; facts, evidence and witness statements are gathered, examined, compared and presented in a logical sequence; narrative summaries are written to clearly show how a preponderance of credible evidence supports the findings; service plans are completed with all component parts; appropriate referrals for services are made; requirements for case closure are met; appropriate supportive documentation is included in the record; appropriate time frames for completion are met; all required entries have been made in the electronic record (see the appropriate Chapters and Appendix in the EPS database Manual). Cases which do not meet these requirements when submitted for closure must be returned to the Specialist. Document this action by entering the event, "Returned for Follow-up" and discuss what changes need to be made with the Specialist and document these in the Staff Notes in the electronic record

F. Monitor

On a weekly basis, monitor and review caseloads and advise EPS Specialists to assure timely provision of services and entry of data into the EPS database, including narrative reports.

At each weekly staffing the supervisor and specialist shall review all cases assigned since the previous staffing, all cases with activity since the previous staffing and all cases with no activity in the last thirty days. No less than once a month, conduct a one on one review with each Specialist supervised of all open cases, all cases on monitoring status, and any cases returned for further action. Program managers must also monitor how well supervisors keep up to date on case monitoring.

G. Administrative and Supervisory Reports

Review reports at least monthly to monitor the status of caseloads and specific investigations. Send weekly reports to the Specialists to document open cases. Each month the Managers and supervisors should review the following reports; Cases Open, Average Days for Investigation Completed, Average Risk Assessment Scores, Average Time Face to Face, Capacity by Specialist, Master Supervisor Report, Monitoring Status, Service Plan Report and Submitted as Complete Not Closed.

H. Coverage

Manage caseloads within supervisory units to assure case coverage when EPS Specialists are on planned or unplanned leave. Keep the EPS Program Manager and the Intake Supervisor informed of EPS Specialists' leave in order to assure adequate coverage of cases. Review leave usage and approve that which will allow the continued effective management of cases.

I. Facilitate

Arrange, coordinate and facilitate interdisciplinary meetings and/or access to expert consultation when warranted by individual cases. Assist local District Attorneys or law enforcement agencies when Elderly Protective Services expertise is needed.

J. Coordinate

Work closely with other state department program offices at the regional and state levels on issues and services relating to EPS clients. Educate program office staff about the service needs of clients on behalf of EPS Specialists such as expediting diagnosis and evaluation, case management, prior authorization and eligibility processes for clients, establishing priority status for EPS clients on waiting lists or finding emergency placements for clients in the least restrictive settings.

K. Training

Assess training needs of EPS Specialists, attorneys, other EPS staff, service providing agencies or the general public as it relates to EPS policies, procedures, guidelines, program requirements, investigative techniques, decision making responsibilities, service needs, safety issues, etc. Help design and deliver this training to staff and others. Conduct training for new EPS Specialists according to established training protocols.

L. Maintain Liaisons

Work with the EPS Specialists to develop liaisons with other community agencies, organizations and providers to establish resources for assisting adults in need of protection, including participating in and supporting the regional Elderly Protective Services Coordinating Councils.

M. Evaluate

Review each EPS Specialist's work for timeliness and thoroughness on an ongoing basis. Remind staff of EPS policy on timely data entry and review the status of each EPS

Specialist's caseload at least monthly. Help set goals to keep caseloads up to date and the number of cases overdue or returned for further information within agency guidelines. Review cases on monitoring status to assure that there is a valid reason to keep cases active. Supervisors should, at least once a year, spend time "shadowing" each worker in order to observe work habits, time management, interviewing skills, etc. This effort should begin with workers who are currently having performance problems, but should be a goal we work toward with all staff.

N. Write

Document in writing at least quarterly each EPS Specialist's performance, reviewing the timeliness of contacts, accuracy and promptness of record entries, and skill of assessment techniques. Complete annual personnel evaluations within the time frames set by GOEA Human Resources.

O. Skill Development

Continue developing skills in supervision and protective services by participating in training available within and outside GOEA as it becomes available.

P. Maintain Case Records

Each supervisor is to document pertinent comments/directions related to case actions, dates and reasons for investigations exceeding 30 days or for cases exceeding 120 days, under the staff notes tab in the case file. When extensions are given, the Supervisor is to enter the number of days the case is extended in the Extension box on the Investigation page of the electronic record in addition to documenting the reason for extension in the Staff Notes section.

II. PERFORMANCE AND DISCIPLINARY GUIDELINES

In monitoring and correcting employee work performance, supervisors shall adhere to the following guidelines:

A. Feedback

To the extent possible, corrective instruction or performance feedback should be employee specific. Avoid management by email or memo, unless a problem is area, section, or agency wide. If a problem affects *most* staff and you must send an email or memo, write it so that it is clear not everyone is having the problem but that all need a reminder of the policy.

B. Individualization

Each worker (including other supervisors) must get individualized attention including both praise for doing good and constructive criticism and corrective "coaching" when needed. Performance issues should be addressed through the Performance Evaluation System

planning documents and review process. Specific issues and areas of needed improvement as well as skill development should be included in the planning. For *serious or ongoing* performance problems, after consultation with agency managers and, if necessary, department human resources and legal staff, there should be a formal counseling meeting which should be documented as described below. Corrective action must be specific to the problem(s) and monitored closely by the supervisor. Every employee is to receive quarterly written performance reviews.

C. Civil Service Regulations and Procedures

Supervisors must be familiar with the Civil Service, GOEA and EPS Discipline Policies. Formal counseling sessions *must* be documented in writing in a memo or letter (*not by email).* The documentation of counseling sessions must be strictly factual, stating the problem, the content of the meeting, and the agreed upon follow-up or corrective action. Supervisors should keep the Program Manager informed of issues of this nature.
Any conduct or situation which a supervisor believes merits a written letter of counseling, a formal supervisory plan, or any type of official disciplinary action must be documented in writing in strictly factual terms and sent to the appropriate Program Manager and the Director. After review and consultation with Human Resources, Legal, and the Deputy Director they will determine a course *o*f action. If a letter of counseling is issued, it will signed by the Appointing Authority. A copy (along with the employee's response, if any) will be filed in the employee's productivity file and in the employee's state office file. Should a situation arise which a supervisor believes warrants immediate disciplinary action, he/she shall consult the appropriate program manager and/or the Director.

Supervisors are not to exempt certain employees from compliance with policy or procedure. There are always situations that merit exceptions to every rule on a case-by-case basis. However, there should be no general exemptions for specific staff members. If an employee is having performance problems due to reasons beyond their control, discuss the matter with the Program Manager and the Director.

Policy must be consistent statewide. Some localized procedures may be needed (especially in facilities), but these must not conflict with agency P & P. When a supervisor sees a need for a revised or new policy or procedure, he/she should discuss it with the program manager and director. If it has merit, it will be implemented statewide.

XV. QUALITY ASSURANCE

The Quality Assurance (QA) system monitors, evaluates and provides feedback to the agency on the performance of the protective service system and whether services provided are of sufficient intensity, scope and quality to meet the individual needs of our clients. It is intended to support workers, supervisors and management at every level within the agency, as well as support the development, implementation and refinement of the protective service delivery system.

Quality Assurance provides more than an audit function. In addition to examining and assessing the components of the agency's service delivery system, QA identifies needs and recommends actions necessary to improve outcomes. This process confirms strengths, identifies successful strategies, and recommends ways in which effective practice and/or system performance can be replicated and/or improved.

I. GOALS OF QUALITY ASSURANCE

The QA program exists to provide a permanent structure for independent, objective evaluations of the quality of protective services and outcomes for our clients. An effective QA process will increase the capacity of the agency to deliver improved services. The ultimate result of the QA program will be improved outcomes for our clients.

A. Approach of Quality Assurance

The approach the QA system uses in working toward these goals includes the following features:

1. Review for the outcomes experienced by our clients who received protective services, particularly the outcome areas of safety, permanency and well-being.
2. Review for the adequacy of internal factors that affect the agency's capacity to deliver services that will lead to improved outcomes for our clients.
3. Review for consistency with applicable state and agency policies.
4. Review for the strengths of the protective service delivery system and the barriers to more effective performance.
5. Recommend corrective actions that address barriers to improved performance

The QA system gathers and uses several types of information to measure

performance.

a. Data reports are used to establish baselines, track progress over time and monitor trends. This information enables the QA system to address questions such as: *how many, how often*, and *at what level*.

b. Qualitative information is used to evaluate the performance of our staff as well as the outcomes for our clients as a result of protective services delivery. This information enables the QA system to address questions such as: *how well, how comprehensive,* and *what are the needs*.

Information obtained from the QA assessment is used to evaluate the systemic issues that affect the agency's capacity to provide protective services that will lead to desirable outcomes for our clients.

II. QUALITY ASSURANCE TECHNIQUES

The agency's QA program uses two techniques:

A. Individual Case Review

Each record is reviewed at the time of closure by the Supervisor to determine if the case meets the agency's requirements for timeliness, completeness of electronic entries, and thoroughness of intervention. This information is recorded in the electronic record.

B. Quarterly QA Methods and Procedures

Each quarter, the Program Monitor will print a detailed report of all cases closed from the previous quarter. The following is the metrics for Quality Control for the EPS program:

1. Approximately 10% of cases closed by each Specialist
2. An appropriate sample of High, Medium, and Low cases
3. An appropriate sample covering each type of primary allegation
4. An appropriate sample covering each type of case disposition at closure

The Program Monitor will then use the QA Monitoring Form to address various aspects of each case and assess the effectiveness and adherence to policy and procedures. The QA results will be reviewed with the Program Manager and Supervisors to reveal trends that will result in necessary trainings to recify the trends.

XVI. TRAINING

Elderly Protective Services has adopted the Multi-Disciplinary Elderly Services Training and Evaluation for Results (MASTER) training curriculum recommended by the National Association of Protective Services Association (NAPSA) and developed by the San Diego State University's Academy for Professional Excellence. MASTER is a training program designed to provide a competency-based multidisciplinary training to Elderly Protective Services specialists and supervisors using core curriculum around practice issues in Elderly Protective Services. The overarching goal is to develop the competency of Elderly Protective Service workers and supervisors to ensure that abused and vulnerable elders receive high quality, effective interventions and services.

I. Specialist Training Requirements

The Elderly Protection Specialists are required to complete the following learning modules: MASTER Core Curriculum

Training modules include scripted trainer and trainee materials, with skill-based learning activities, handouts, evaluation material and PowerPoint Presentations. Each module includes documentation to support supervisors in assisting staff with transfer of learning skills in the work environment.

BASIC AND ADVANCED SKILLS

1. Introduction to EPS, Definition, Organization	Reading Assignment in Policy and Procedure Manual
2. APS Worker Safety	CPTP
3. The APS Intake Interview	CPTP
4. Professional Communication	CPTP
5. Field/Shadowing	Supervisor/Shadowing
6. Field/Shadowing	Shadowing
7. Clients with Communication Deficits	e-learning
8. Dynamics of Abusive Relationships	Supervisor Led
9. Policy & Procedure Manual	Self-learning

(Read)	
10. Self-Neglect	CPTP
11. Physical Abuse	CPTP
12. Sexual Abuse	CPTP
13. Caregiver Neglect	CPTP
14. Financial Exploitation	CPTP
15. Investigation Skills Capacity	CPTP
16. Investigation Skills Assessment	CPTP
17. Mental Health Issues Part 1	e-learning
18. Mental Health Issues Part 11	e-learning
19. Substance Abuse Issues	e-learning
20. Collaboration & Resources	Reading Assignment in Policy & Procedure
21. Legal Issues & Exploration	Reading Assignment in Policy & Procedure
22. Case Closure	Reading Assignment in Policy & Procedure
23. APS Case Documentation	e-learning
24. Field/Shadowing	shadowing
25. Involuntary Case Planning	Supervisor Led
26. Voluntary Case Planning	Blended (e-learning and Supervisor)
27. Field/Shadowing	Shadowing

Specialists must complete the above training prior to receiving case assignments.

Specialists are required to attend additional training developed and provided by management.

II. Supervisor Training Requirements

Supervisors are required to complete the same training as the Specialists, plus the following:

1. All CPTP Supervisory Training
2. Additional Supervisor Training Modules:
    a. Supervisor as trainer
    b. Working with less
    c. Understanding Self as Supervisor
    d. Foundations of Effective Supervision
3. Other training provided by Management

QUALIFIED SERVICE ORGANIZATION AGREEMENT

The Department of Health and Hospitals, Office of Alcohol and Drug abuse (OADA) and the Department of Health and Hospitals, Bureau of Protective Services (BPS) hereby enter into a qualified service organization agreement whereby BPS agrees to provide the following:

1. referral of BPS clients who appear to be in need of and eligible for OADA services;

2. assistance with discharge planning for mutual clients of BPS and OADA; and

3. follow-up to assist in stabilization of mutual clients of BPS and OADA with regard to a client's living situation, home environment, and other factors which affect the client's treatment and/or vulnerability to abuse, neglect, or exploitation.

Furthermore, BPS:

1. acknowledges that in receiving, storing, processing or otherwise dealing with any information from OADA clients, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2;

2. undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

Executed this 13th day of April, 1998

Office of Alcohol and Drug Abuse
Assistant Secretary

Bureau of Protective Services
Director

MEMORANDUM OF UNDERSTANDING
REGARDING INTER-AGENCY TRANSFER FROM
THE DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF AGING AND ADULT SERVICES
ADULT PROTECTIVE SERVICES
TO
THE GOVERNOR'S OFFICE OF DISABILITY AFFAIRS

In order to facilitate the accomplishment of duties and responsibilities assigned to the Governor's Office of disability Affairs (GODA) by The Department of Health and Hospitals, Office of Aging and Adult Services (OAAS) pursuant to the Adult Protective Services Law (R.S. 14:403.2), the two agencies agree to the following provisions:

1. The Department of Health and Hospitals, Office of Aging and Adult Services agrees to provide GODA funding in the amount of $60,000 to be used to purchase money management, curatorship, or continuing tutorship for the persons, property or both of adults with disabilities found to be in need of protective services in Louisiana. OAAS agrees to reimburse GODA upfront funding in the amount of $60,000 no later than July 31st of the 2010-2011 fiscal year. GODA shall retain 10% administrative cost, equal to $6,000 associated with administering this MOU. This funding covers up to 31 persons served per month for a 12 month fiscal year.

2. When OAAS, Adult Protective Services (APS) during, or on completion of, an investigation of abuse, neglect, exploitation or extortion finds that an adult with disabilities is in need of assistance with money management or is need of guardianship services, APS reviews the case according to internal policies and procedures and will notify Louisiana Guardianship Services, provide the information necessary to arrange the services and notify GODA that a referral has been made.

3. The Governor's Office of Disability Affairs will contract with Louisiana Guardianship Services to provide money management or guardianship service. The contr4actor will act as limited or full curator or provide services for persons who have been approved for services by the Office of Aging and Adult Services, Adult Protective Services. Contractor will forward to OAAS/APS copies of documents identifying Contractor as the guardian or payee for each person they serve. All guardians will be certified as registered guardians and all services will be provided in accordance with the National Guardianship Association's Code of Ethics and Standards of Practice, latest editions. Contractor will provide training in issues related to guardianship. Contractor will forward to OAAS/APS copies of documents identifying LGS as the guardian or payee for each person they serve.

4. GODA will monitor the contract to determine that the services are provided by Contractor in accord with contract terms, provide reports to OAAS on the number of persons served and types of services provided to each person during each quarter. GODA will notify OAAS/APS of any complaints made by or on behalf of persons served. GODA shall approve LGSI invoices for payment based on Contractors satisfactory performance of contract terms, and assume all other contact responsibilities including:

receipt, review, and approval of monthly status summaries from LGSI, troubleshooting, contract management, & contract monitoring.

5. Information transferred between or among these agencies shall be maintained in accordance with the confidentiality provisions of applicable revised statues, the administrative rules of the respective agencies, and other applicable state or federal laws, rules, or regulations.

This agreement will remain in effect indefinitely unless a request is initiated by either OAAS-APS or GODA to address agency appropriate revisions.

Signed and approved on this_____day of_____, 2010.

_____
Executive Director
Governor's Office of Disability Affairs
H. Brandon Burris

_____
Director, Adult Protective Services
Ellen Estevens

_____
Deputy Director
Office of Community Programs
Tammy Woods

_____
Assistant Secretary, Office of Aging and Adult Services
Hugh Eley

_____
Director of Finance and Administration
Terrence Ginn

_____
Secretary, Department of Health and Hospitals
Alan Levine

OFFICE OF ELDERLY AFFAIRS

VIOLENCE/THREAT INCIDENT REPORTING FORM

Section I

NAME: _____ DATE: _____

UNIT: _____ DATE/TIME OF INCIDENT _____

LOCATION OF INCIDENT _____

_____

Section II

DESCRIBE INCIDENT AND WHO WERE INVOLVED _____

_____

_____

_____

SIGNATURE: _____

INVESTIGATION OF INCIDENT

Section III

NAME/TITLE OF INDIVIDUAL INVESTIGATING INCIDENT _____

_____ DATE _____

RESULTS OF INVESTIGATION _____

_____

_____

_____

SIGNATURE _____

ACTION(S) TAKEN AS RESULT OF INVESTIGATION

Section IV

_____

_____

_____

SIGNATURE: DATE:

CHAIN OF COMMAND VERIFICATION

SUPERVISOR: _____ DATE: _____

MANAGER: _____ DATE: _____

DIRECTOR: DATE:

INSTRUCTIONS FOR COMPLETING INCIDENT REPORTING FORM

I. **Employee completes and signs Sections I and II**
   a) **Make two (2) copies**
      - **retains one**
      - **forwards one to Safety Coordinator**
   b) **forwards original to supervisor**

   ***NOTE**: If incident involves Supervisor, forwards to Manager, etc.*

II. **a) Supervisor or Manager conducts Investigation and completes Investigation/ Action Sections (Sections III & IV).**

   b) Upon completion of investigation, Supervisor meets with employee who originally filed report and explains his/her Findings and Action(s) to be taken.

   ***NOTE**: It is advisable that someone else be present in this meeting (Manager, Safety Coordinator, Human Resources Director)*

   c) Signs/dates form and make two (2) copies
      - **retains one copy for files**
      - **forward original to Executive Director/Agency Head**

III. **a) The Executive Director/Agency Head reviews the form. (Takes whatever action is necessary) and Signs/Dates**

   b) Forwards original to Personnel to be placed in file, a copy to the Safety Coordinator and a copy to the employee.

NOTE: CHAIN OF COMMAND SECTION MUST BE COMPLETED

PLAN A SAFETY MEETING IN WHICH THE AGENCY'S VIOLENCE IN THE WORKPLACE POLICY IS EXPLAINED THOROUGHLY AND EACH EMPLOYEE RECEIVES A COPY OF THE INCIDENT REPORTING FORM.

NOTE: A presentation can also be included in this Safety Meeting.

APS Risk Assessment Matrix:

Client Name_____ Incident Number_____

Initial Score in 1st Column. Date_____ Follow-up Score in 2nd column. Date_____

Client Factors

For each factor, the tool includes descriptions or examples of situations. **It is important to remember that these examples are not all inclusive nor does the client have to meet all examples listed in a risk level.** Investigators should feel free to mark the level of risk that seems most appropriate even though the given description does not exactly correspond to the client's condition. It is recommended that you underline, highlight, or notate the situation which applies to the client and/or upon which your rating is based.

Risk Factor	High Risk Examples 3	Medium Risk Examples 2	No/Low Risk Examples 1	1st	2nd
1. Physical Health & Functional Abilities	Bed or chair bound. Severe and functionally limiting disability. Completely dependent on others, chronic disease, rapid deterioration of functional abilities.	Moderate physical disability. Difficulty ambulating; requires prosthesis or hands-on assistance to be ambulatory. Occasionally non-ambulatory. Needs assistance with some ADLs.	Ambulatory, minimal physical disability. Capable of performing ADLs without assistance.		
2. Mental/Emotional Health	Severe/profound intellectual disability. Severe functionally limiting mental illness. Confusion; severe memory loss; consistently not oriented to time, place, or person. Recent or rapid deterioration of mental/ emotional health. Severe depression, suicidal ideation. Refuses needed services.	Moderate/mild intellectual disability. Periodic confusion; some memory loss; occasionally not oriented. Impaired reasoning abilities. Decompensated mental illness. History of eccentric behavior. Moderate depression. Resists accepting needed services.	No intellectual disability. No current mental/emotional problems or mental illness is controlled. Fully oriented. Willingness to accept needed assistance.		
3. Alcohol or substance use/abuse	Active Alcohol or substance abuser. Consistently intoxicated. Uses illicit drugs: misuses medications to get high, which poses immediate health risk.	Periodic episodes of alcohol or substance abuse. Occasionally over medicates (such as combining alcohol and other substances) or abuses prescription medication to get high..	No evidence of alcohol or illicit drug use. Takes medications as prescribed.		

STOP! BASED ON ABOVE FACTORS, IS CLIENT "SUBSTANTIALLY DISABLED"? IF ALL THREE FACTORS ARE NO/LOW RISK, CLIENT MAY NOT BE ELIGIBLE FOR SERVICES. IF YOU BELIEVE CLIENT IS UNABLE TO PROVIDE FOR OWN CARE AND/OR PROTECTION ANYWAY, EXPLAIN WHY BELOW. IF CLIENT IS NOT ELIGIBLE BUT IN NEED OF SERVICES, REFER TO APPROPRIATE AGENCY(S).

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Replacing 10/22/02 issue

Client Factors (Continued)

4. Capacity	Unable to understand the impact of potential decisions and/or determine alternatives. Unable to receive and evaluate information or to communicate decisions.	Limited understanding of impact of potential decisions; limited ability to determine alternatives. Limited ability to receive and evaluate information or to communicate decisions.	Fully able to understand impact of potential decisions and determine alternatives. Able to receive and evaluate information and communicate decisions		
5. Financial resources & money management	Totally dependent on others financially, or, regardless of income, unable or unwilling to manage funds and/or provide for necessities.	Partially dependent on others financially. Marginal resources; cannot always provide for necessities - must sometimes choose between needs, e.g. medicine vs. food.	Adequate. Independent. Able to provide for necessities. Controls own resources or has reliable assistance.		
6. Food & Nutrition	No food, malnutrition. Inability to shop for or prepare meals. Special diet required.	Sometimes needs assistance in shopping for or preparing meals. Appetite poor. Does not always eat balanced meals.	Adequate food available. Able to shop & prepare. Adequate nutrition.		
7. Compliance with medical/ treatment regime	Consistently disregards medical/treatment advice; does not take medication as prescribed; unable to comply without assistance (e.g. manage own meds).	Occasionally disregards medical/treatment advice to detriment of health. Needs some assistance in compliance.	Compliant with medical/treatment regime. Able to carry out without assistance.		
8. Client Viewpoint	Does not recognize or understand problem. Rejects help or blames APS.	Understands problem, but has no adequate plan to deal with it. Little motivation to change situation. Makes excuses or doesn't cooperate.	Understands problem and has a plan to deal with it. Works with APS to solve problem. Accepts assistance.		

Environmental Factors NOTE: If client is HOMELESS, score #'s 9-11 as 3 and make notation at bottom of page.

9. Structural soundness of home	Inadequate for client needs. Safety hazards. Structurally unsound.	Shelter needs improvement but poses no immediate safety hazard. Generally adequate for client needs.	Shelter is adequate. No safety problems.		
10. Sanitation	Severe pest infestation. Human/animal waste present. Spoiled piles of garbage/papers.	Trash/garbage not disposed of. Some evidence of pest infestation. Some odors.	Meets minimal standards of cleanliness. No odors, trash not exposed.		
11. Utilities	No electricity, gas. No running water.	Overdue bills. Threatened or previous cut off. Problems in very hot or cold weather.	Adequate utilities.		
12. Support System	Socially isolated. No one available or willing to assist. No knowledge of formal service system. Unable to access services. Lacks a willing/effective advocate.	Family somewhat supportive but not in geographic area. Limited support from family, friends, neighbors. Support is irregular. Limited knowledge of available services.	Family, friends, neighbors, available, willing and able to provide or arrange services. Has well-informed, effective advocate. Known to service system; already receiving services.		
13. Availability, access to, and reliability of services	Geographically isolated from community services. Long waiting lists. Services unreliable or not available as needed.	Limited community services, or short-term waiting list. Services are somewhat unreliable. Transportation is unavailable or unreliable.	Adequate and reliable community services. Client able to leave residence. Transportation available.		

14. Severity of Physical or Psychological abuse	Client requires immediate medical treatment. Any sex abuse or any injury to head, face, genitals. Escalating pattern of severe abuse. Client evidences serious psychological effects of abuse of abuse.	Minor or unexplained injury (limited to bony parts, buttocks or torso) requiring medical treatment. Pattern of increasing severity of abuse. Client showing some adverse psychological effects of abuse (fear, anger, withdrawal, depression, etc.)	None or minor injury limited to bony parts, i.e., knees, elbows. Injury resulting from routine accident. No apparent psychological effect on client.		
15. Frequency/severity of exploitation or extortion of person or property.	Any exploitation or extortion which threatens the health, safety, independence, or well-being of the client, or deprives client of basic necessities. Any systematic misuse or client's resources, e.g. fraud, forgery.	Pattern of ongoing exploitation or extortion which, if unchecked, could threaten health, safety, independence, or well-being of client.	None, or with little, if any, impact of client's health, safety, independence, or well-being.		
16. Severity of Neglect	Client requires immediate intervention (medical treatment, placement, emergency services, etc.) Client at risk of death or serious harm for lack of adequate care or supervision.	Deprivation of adequate supervision or basic needs, e.g. medical care, food, shelter, etc. which if unchecked, will endanger the health and well-being of client.	None. Isolated, explainable incident. No pattern of neglect or neglect with little risk to client.		
17. Quality of or Consistency of care	Client is at risk due to self/caregiver irresponsibility or lack of knowledge, skills and abilities of caregiving. Client lives alone and has diminished mental and/or physical capacity.	Client/caregiver provides care, but knowledge, skills and abilities or degree of responsibility are problematic and may contribute to risk.	Client/caregiver is well informed, responsible and provides the degree of care required.		

Abuse, Neglect, Exploitation (Continued)

18. History of Abuse, neglect, exploitation	On-going history or pattern of increasing frequency or intensity of violence, abuse, neglect, or exploitation. Any previous valid report. History of violence in family as means of conflict resolution.	Any previous report (to APS, law enforcement, medical, etc.) of violence, abuse, neglect, or exploitation. History of significant conflict within family. On-going history of abuse, neglect, or exploitation.	No known history of violence, abuse, neglect, or exploitation. No history of significant family dysfunction.		

STOP! Total the scores from the far right column and enter the total score here:

Initial Score _____ Follow-up Score_____

If the allegations *only* involve self-neglect, stop here. THIS IS THE TOTAL RISK ASSESSMENT SCORE FOR SELF-NEGLECT CASES. Enter this number in the appropriate box in theelectronic record.

If the total score is: 18 or below = no/low risk.
19-38 = intermediate risk
39-57 = high risk.

Investigator's overall assessment of risk (circle one) (SELF-NEGLECT ONLY): Initial: High Intermediate No/Low
Follow-up: High Intermediate
No/Low

NOTE: Your overall assessment need not correspond to the numerical score, because one or two factors scoring HIGH may override several factors scoring LOW or INTERMEDIATE. FOR EXAMPLE: If there is an increasing frequency of non-compliance with medications for a mentally ill client, that factor might override low scores for physical health, support services, home environment, etc.

Investigator's Initials _____

If the allegation(s) involves an accused or caregiver, complete the remaining factors.

Accused/Caregiver Factors:

19. Accused/caregiver Cooperation with Investigation	Refuses to cooperate or provides very little cooperation. Despite evidence, doesn't acknowledge there is a problem.	Minimal cooperation; only with constant encouragement or support.	Aware of problem: cooperates to resolve problem and protect client.		
20. Accused/caregiver Physical Health	Severe and functionally limiting physical disability; chronic or uncontrolled disease. Recent deterioration of health.	Physical handicap and/or occasional physical difficulties. May be in poor health or have poorly controlled chronic illness.	Good health or minimal, but controlled, physical difficulties.		
21. Accused/caregiver Mental/emotional health/control	Severe and functionally limiting mental disability; history of chronic or uncontrolled mental illness. Desire to harm the client; overly concerned with clients' "bad" behavior. Bizarre or violent behavior; suicidal. Unresponsive to the client. Asks to be relieved: threatens client with institutionalization. Recent deterioration of mental/emotional health or control.	Periodic mental/emotional difficulties or problems of control. Poor reasoning abilities. Immature, dependent or has unrealistic expectations. Somewhat unresponsive to client. Periodic alcohol/substance abuse. Parasitic or opportunistic behavior.	No, or minimal but controlled, mental or emotional difficulties. Responsive to client. Realistic expectations of the client; can plan to correct the problem.		
22. Accused Access to Client	Complete, unrestricted access to client.	Unpredictable presence of others in the home. Limited opportunity to be alone with client. Despite allegations, uncertainty if others will deny access to client.	Never or rarely alone with client. Client has frequent, regular contact with others in or out of the household.		

Accused/Caregiver Factors (Continued):

23. Situational stress/ response to home crises (e.g. the investigation, recent birth, death, marital difficulties, hospitalization, caregiving responsibilities, unemployment, financial problems)	Gross overreaction or highly inappropriate reaction to stress/life crises, e.g. severe depression, hopelessness, violation of societal norms. Caregiver suffering chronicfatigue.	Difficult, prolonged, inappropriate or unrealistic adjustment to situational stress/life crises, e.g. frustration, fatigue, depression, anger.	Realistically adapts and adjusts to situational stress/life crises.		
24. Client's reaction to caregiver	Fearful, intimidated, agitated in his/her presence. Seriously distressed in his/her presence. Self-Reports physical or sexual abuse.	Some emotional distress in his/her presence. Self-Reports verbal/emotional abuse, neglect.	No self-reports of any abuse/neglect/ or exploitation. No apparent emotional distress in his/her presence.		
25. Accused/client dynamics contributing to risk	Client fears or has irrational desire to protect accused. Any bond that causes client or caregiver (if not accused) to tolerate ANE, e.g. client or caregiver emotionally dependent or obsessed with accused.	Client makes excuses for or desires to protect the accused because of blood relationship, concern over consequences, guilt, shame, or low self-esteem. Client guarded or reluctant to discuss allegations.	Normal relationship. No apparent fear or reluctance to discuss allegation. No apparent special problems.		
26. Financial resources/ Dependency on the client	Accused is financially dependent on client. History of parasitic or opportunistic behavior.	Feels obligated to care for the client by financial necessity or blood relationship. Client or caregiver provides partial or supplementary support. Some indication of parasitic or opportunistic behavior.	Financially independent or not wholly dependent on the client for income.		

Accused/Caregiver Factors (Continued):

27. Substance Abuse and other special problems	Chronic substance abuse/alcoholism or special problems.	Episodic substance or alcohol abuse or other special problems.	No apparent special problems or alcohol or substance abuse.		

STOP! Total the scores from the accused section and enter here: Initial Score_____ Follow-up Score _____

Enter the sub-total from the first section here: _____ _____

ADD THE TWO NUMBERS AND ENTER HERE: _____ _____

THIS IS THE TOTAL RISK ASSESSMENT SCORE FOR CASES INVOLVING A CAREGIVER/ACCUSED.
Enter this number in the appropriate box in the database.

If the total score is: 27 or below = no/low risk.
28-54 = intermediate risk
55-81 = high risk.

Investigator's overall assessment of risk (circle one): Initial: High Intermediate No/Low

Follow-up: High Intermediate No/Low

NOTE: Your overall assessment need not correspond to the numerical score, because one or two factors scoring HIGH may override several factors scoring LOW or INTERMEDIATE.
FOR EXAMPLE: If there is an escalating pattern in the severity of abuse and the accused has unrestricted access to the client, these factors would override low risk scores for mental health, adequacy of support system, etc.

Investigator's Initials_____

APS Risk Assessment Matrix
INSTRUCTIONS

Purpose and Scope

The Risk Assessment Matrix is designed to fulfill two purposes. First, it is a means of developing a numerical score which reflects overall risk to the client from abuse, neglect, exploitation or extortion. Comparing the score at the time of the initial face-to-face with the score at the time of case closure provides a quantitative measure of whether APS intervention improved the client's situation. This measure has been adopted, in part, in response to the requirement that programs have *measurable* indicators of outcomes.

The second purpose of the Matrix is to serve as a guideline for investigators to ensure that they have thoroughly considered *all* relevant factors in assessing the degree to which a client is at-risk. The factors included in the Matrix are derived from a study of risk assessment tools used by APS programs around the country. About 60% of APS programs use a similar tool. The factors are those most commonly found in such tools, many of which have been shown in research studies to be accurate predictors of abuse/neglect/exploitation.

A critical point that must be kept in mind in using the tool is that it serves only as a *guide* to assist the investigator in assessing risk. **The ultimate decision to call a situation high, intermediate, or low risk is still one that must be made by the investigator, based on his/her professional judgement.** In other words, the investigator's assessment of risk *may or may not* agree with the numerical score. This is due to the fact that one or more items scored as high risk can override a majority of items scored lower.

For example, a client may be physically disabled, with little or no mental or cognitive problems, live in a good home, and have adequate support services. These factors would tend to make the numerical score fall in the intermediate or low range. However, if the client is being physically abused by someone who has unrestricted access, that high risk item would cause the overall assessment to be considered high risk. As another example, a client reported for self-neglect may have excellent physical health, a concerned family, and adequate financial resources. However, if the client has a recurring pattern of non-compliance with mental health treatment, that factor could cause the overall assessment to be high risk.

General Instructions

The Matrix is to be completed on all clients. However, as explained below, it may not be necessary to complete the entire tool on every client. The Matrix is not an interactive tool. In other words, there are no direct questions to be asked of the client. It is expected that the investigator will complete the tool based upon his/her knowledge

of the factors as determined through the investigation.

For each factor, the tool includes descriptions or examples of situations which would be considered high, intermediate, and no/low risk. **It is important to remember that these examples are not all inclusive.** It is impossible to list every situation that might apply to a given client. Therefore investigators should feel free to mark the level of risk that seems most appropriate even though the given description does not exactly correspond to the client's condition. It is recommended that you underline, highlight, or notate the situation which applies to the client and/or upon which your rating is based.

The Matrix is to be completed twice; at the time of, or immediately following, the initial face-to-face with the client, and at the time the case is closed. Ideally, the second score (and the investigator's overall assessment) will be lower than the initial score. This will reflect that APS intervention has reduced the level of risk.

There will be cases where the score may not change. This could be due to a variety of factors. If this case is invalid, the initial score would generally be expected to be no/low risk, and if no services are needed, the score may not change. It is nevertheless important to complete the second assessment. If services are needed and referrals made, the score may improve, reflecting that APS intervention did help the client even though abuse could not be confirmed. In some valid cases the score may not improve. For example, a client with capacity to consent may refuse services, there may be a waiting list for needed services, or no effective intervention may be possible for other reasons. **If a case is valid, it is critical that investigators document in the case record and in the final report the reasons why the level of risk did not improve.**

Specific Instructions for Completing the Matrix

1. Enter the client's name and the incident number at the top of the form.

2. Enter the date the Matrix was completed (for both initial and follow-up).

3. Client Factors: Determine the level of risk for each factor and enter the appropriate number in the column at the far right. For the initial assessment use the first column. For the follow-up use the second column.

High Risk =	3
Intermediate Risk =	2
No/low risk =	1

4. The first three factors are designed to aid in assessing the degree to which the client meets the definition of "disabled" in the APS law. If the client scores a 3 or a 2 on *any one* of these factors, he/she is considered to be unable to provide for his/her own care and/or protection without assistance and therefore meets the

definition. If a client scores a 1 on all three factors, he/she *may* be able to provide his/her own care or protection and may not be eligible for APS services. Remember that the investigator's professional judgement is the deciding factor. If the investigator believes the client is unable to provide for his/her own care and/or protection without assistance, *even though the scores are all 1s,* explain why in the space provided and continue with the assessment. If the investigator believes the client is not eligible, the reasons must be documented and the case may be closed, provided any appropriate referrals are made and documented.

5. Environmental Factors: Complete in the same manner as the client factors. If the client is homeless, items 9-11 should be scored as 3s and a note should be made on the form.

6. The client and environmental factors constitute the first part of the Matrix. Following factor number 18, the scores from the right hand column should be totaled and entered on the appropriate line (initial or follow-up score) on Page 5. **If the case involves only self-neglect, this is the end of the assessment. The investigator will circle his/her overall assessment (high, intermediate, no/low) on Page 5 and initial in the space provided.** Remember the investigator's overall assessment need not be the same as the numerical score. **If your overall assessment is different from the numerical score, your reasons must be documented on the form or in the case record and in the final report.** If the case is not self-neglect, leave the overall assessment blank and continue with the assessment.

7. Accused/Caregiver Factors: Complete these factors regarding the accused or primary caregiver using the same scoring system. Total the scores from these factors (numbers 19-27) and enter the sub-total in the appropriate first line on Page 8. On the second line on Page 8, enter the sub-total from Page 5. Add the two numbers and enter the total on the third line on Page 8. **This number is the total score for cases involving a caregiver or accused.** If there is more than one accused, you need not complete separate assessments on each. Complete the accused factors based on a composite rating, on the accused for whom the case is valid, or the one who represents the greatest risk, whichever is most appropriate.

The investigator will circle his/her overall assessment (high, intermediate, no/low) on Page 8 and initial in the space provided. Remember the investigator's overall assessment need not be the same as the numerical score. **If your overall assessment is different from the numerical score, your reasons must be documented on the form or in the case record and the final report.**