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September 29, 2023

Members of the Arizona Legislature

The Honorable Katie Hobbs, Governor

Ms. Angie Rodgers,
Cabinet Executive Officer and Executive Deputy Director
Arizona Department of Economic Security

Ms. Jennie Cunico, Acting Director
Arizona Department of Health Services

Ms. Carmen Heredia,
Cabinet Executive Officer and Executive Deputy Director
Arizona Health Care Cost Containment System

Transmitted herewith is a report, *Examining the Delivery of Service to Vulnerable Adults in the Arizona Adult Protective Services System*. This examination was conducted by the independent firm LeCroy & Milligan Associates, Inc. under contract with the Arizona Auditor General and was in response to Laws 2022, Ch. 313, §55.

As outlined in its response, the Arizona Department of Economic Security agrees with all the chapter conclusions and plans to implement or implement in a different manner all the recommendations directed to it. In addition, the Arizona Department of Health Services, and the Arizona Health Care Cost Containment System both agree to and plan to implement the 1 recommendation directed to them. My Office has contracted with LeCroy & Milligan Associates, Inc. to conduct an initial followup with these entities to assess their progress in implementing the recommendations.

I express my appreciation to Cabinet Executive Officers and Executive Deputy Directors Rodgers and Heredia and Acting Director Cunico and their departments' staff for their cooperation and assistance throughout the examination.

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

Examining the Delivery of Services to Vulnerable Adults in the Arizona Adult Protective Services System

September 28, 2023





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Dear Ms. Perry:

LeCroy & Milligan Associates is pleased to submit our final report *Examining the Delivery of Services to Vulnerable Adults in the Arizona Adult Protective Services System* in response to the Auditor General's Office (Office) request for proposals released on June 30, 2022. This report presents the results of investigating the current adult protective services system and provides recommendations to improve the delivery of services to vulnerable adults in Arizona.

We appreciate the opportunity to have been of service to the Office of Auditor General and it has been our pleasure to work with you and your staff. We also appreciate the cooperation we received from those who assisted us in our review including the Department of Economic Security, Arizona Health Care Cost Containment System, Arizona Department of Health Services, Arizona Area Agencies on Aging and our team of expert, national consultants.

Sincerely,

A handwritten signature in black ink, appearing to read "Craig LeCroy".

Craig LeCroy, PhD
Director of Research

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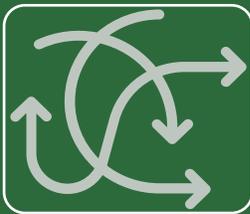
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HIGHLIGHTS

Audit Purpose Laws 2022, Ch. 313, §55, directed the Arizona Auditor General to engage an independent consultant to examine the current adult protective services system and consider best practices to improve the delivery of services in this state.

Key Findings We determined several state agencies, other public entities, and nonprofit organizations have roles and responsibilities related to Arizona’s adult protective services system; however, the primary agency and program responsible for protecting vulnerable adults in the State is the Arizona Department of Economic Security’s Adult Protective Services Program (DES APS). We also identified several gaps in the system preventing the effective delivery of services that should be addressed to help ensure vulnerable adults are protected and receive the services they need. Specifically:



Arizona’s adult protective services system lacks a strategic direction which would be important for ensuring vulnerable adults are protected from abuse, neglect, and exploitation and receive the services they need.



Arizona’s adult protective services system lacks a case management process for ensuring vulnerable adults receive services and key outcome data for assessing system effectiveness.



Arizona’s adult protective services system community engagement practices align with national guidance and other state practices, however, there are opportunities to more directly involve vulnerable adults and their families.

A summary of our recommendations to help ensure vulnerable adults are protected and receive the services they need during and after an investigation are presented below:

Key Recommendations

Establish a working group – DES should work with the Governor, President of the Arizona Senate, and Speaker of the Arizona House of Representatives to establish and appoint members to a working group to develop a strategic direction for Arizona’s adult protective services system.

Develop report identifying roles / responsibilities and other needs – DES in conjunction with the working group should develop a report that identifies the working group’s roles and responsibilities and identifies any authority, resources, legislation, or other action needed to ensure the working group’s ongoing success in identifying and implementing the strategic direction for Arizona’s adult protective services system.

Develop and implement a strategic direction and address system gaps – DES in conjunction with the working groups should develop and implement a strategic direction for Arizona’s adult protective service system and then take steps to address the additional gaps identified, including determining whether a specific state agency should be assigned the responsibility of case management services to help ensure that vulnerable adults receive the services they have been referred to after a DES APS investigation; and, identifying a system-wide performance reporting process that could compile performance and outcome information on an annual basis to assess the effectiveness of Arizona’s strategic direction.

Obtain input from vulnerable adults – DES in conjunction with the working group should involve vulnerable adults and their families in the development of the strategic direction for Arizona’s adult protective services system.

We also have identified the following areas for future independent review of Arizona’s adult protective services system.



Recommended Areas for Future Independent Reviews

DES APS' investigation process, including timeliness and quality;
Barriers for vulnerable adults to obtaining guardianship and the role and effectiveness of public fiduciaries;
Barriers for vulnerable adults to receive services, including availability of services in rural areas; and
Effectiveness of agreements between DES APS and Tribal authorities.

INTRODUCTION

Audit Scope and Purpose

Laws 2022, Ch. 313, §55, directed the Arizona Auditor General to engage an independent consultant to examine the current adult protective services system and consider best practices to improve the delivery of services in this state. The Arizona Auditor General hired LeCroy & Milligan Associates, Inc. to conduct this examination.

We determined several state agencies, other public entities, and nonprofit organizations have roles and responsibilities related to Arizona's adult protective services system; however, the primary agency and program responsible for protecting vulnerable adults in the State is the Arizona Department of Economic Security's Adult Protective Services Program (DES APS). DES APS is responsible for receiving concerns about vulnerable adults, investigating whether these adults have been subjected to maltreatment, determining what services they may need, and referring them to other entities for services. The DES Director is also responsible for making final decisions, based on recommendations from the Attorney General's Office, on whether allegations of maltreatment are substantiated and whether the perpetrator(s) name(s), date(s) of birth, and allegation description(s) are added to the DES APS Registry, which DES APS is responsible for maintaining. Other entities also involved in the system include those responsible for: reporting allegations of vulnerable adult maltreatment to DES APS, known as mandated reporters, such as law enforcement personnel and health care workers; agencies which license facilities where some vulnerable adults may reside, such as the Arizona Department of Health Services (ADHS); and providing some services, such as Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), and DES' Division of Developmental Disabilities (DES DDD). See Chapter One, pages 5 through 21 for more information on these various entities.

We also identified several gaps in the system preventing the effective delivery of services that should be addressed to help ensure vulnerable adults are protected and receive the services they need. Specifically:

- Arizona's adult protective services system lacks a strategic direction which would be important for ensuring vulnerable adults are protected from abuse, neglect, and exploitation and receive the services they need (see Chapter Two, pages 22 through 33).
- Arizona's adult protective services system lacks a case management process for ensuring vulnerable adults receive services and key outcome data for assessing system effectiveness (see Chapter Three, pages 34 through 42).

- Arizona's adult protective services system community engagement practices align with national guidance and other state practices, however there are opportunities to more directly involve vulnerable adults and their families (see Chapter Four, pages 43 through 48).

In addition, we identified important processes that warrant future review, including reviewing DES APS' investigation process; examining barriers to obtaining guardianship and the role of public fiduciaries in providing services to vulnerable adults; reviewing potential barriers to vulnerable adults receiving services available to all older adults, including service provider staffing capacity, case prioritization, and availability of services in rural areas; and reviewing agreements between DES APS and tribal authorities (see Chapter Five, pages 49 through 55).

CHAPTER ONE - OVERVIEW OF ARIZONA'S ADULT PROTECTIVE SERVICES SYSTEM

DES APS Responsible for Receiving Reports of Abuse, Neglect, and Exploitation of Vulnerable Adults

DES APS is responsible for receiving reports of abuse, neglect, self-neglect, or exploitation of vulnerable adults 18 years of age or older (see textbox for a definition of vulnerable adult and other key terms). Reports can come from a variety of sources including the public; family members; and professionals who are statutorily required to report allegations of vulnerable adult maltreatment to DES APS, known as mandated reporters, such as law enforcement and medical personnel. Individuals can file a report through a phone hotline, 1-877-SOS-ADULT, and a form on the DES website.¹

When DES APS receives a report, its Central Intake Unit (CIU) Customer Service Representatives (CSR) are responsible for reviewing the report, determining if the individual qualifies as a vulnerable adult, and if maltreatment is probable based on information provided by the reporter. According to DES APS case level data analyzed for the review, DES APS received 73,083 reports that met criteria for an investigation from fiscal year 2020 to 2022. Exhibit 1 below shows the different types of maltreatment, self-neglect, and abuse for reports received during the same period.

KEY TERMS

A vulnerable adult is defined as an individual aged 18 and older, who is unable to protect themselves due to a physical or mental impairment, or whom a court has deemed incapacitated. [A.R.S] §§ 46-451 and 14-5101

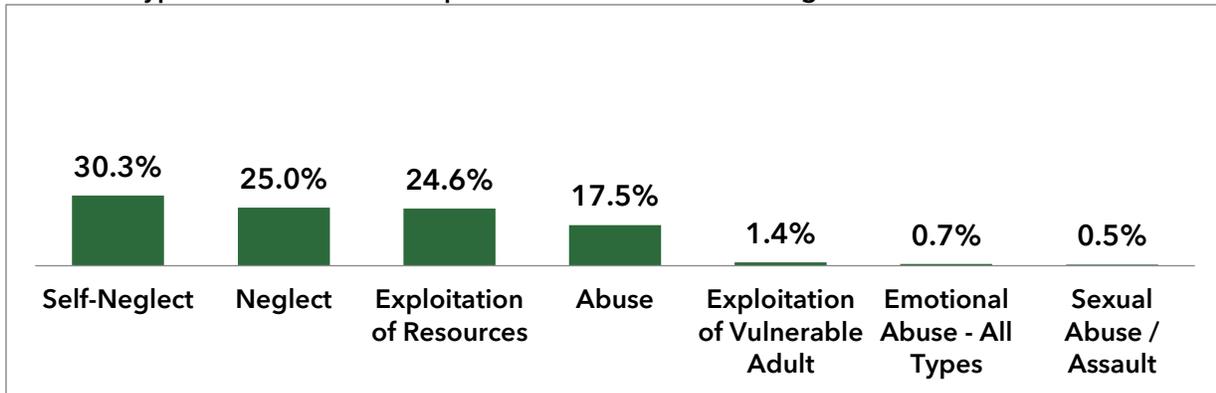
Maltreatment consists of abuse, neglect (including self-neglect), or exploitation. DES APS CIU Policy

An allegation is a reported occurrence and type of maltreatment associated with each vulnerable adult that is investigated. There may be multiple allegations in an investigation. DES APS CIU Policy

Mandated reporters are individuals who are statutorily required to report or cause reports to be made to a peace officer or to the DES APS Central Intake Unit. Reports are to be made immediately by phone or online. Mandated reporters include but are not limited to medical personnel, including physicians, registered nurses and other persons who have responsibility to care for vulnerable adults; and financial personnel including attorneys, accountants and other persons who have responsibility for any other action concerning the use or preservation of a vulnerable adult's property. [A.R.S] §§ 46-454

¹DES APS. *Adult Protective Services Online Submission Form*.
<https://hssazapsprod.wellsky.com/assessments/?WebIntake=1F74FCDA-C6AB-4192-9CEE-F8D20DE98850>

Exhibit 1. Types of Maltreatment Reports Fiscal Years 2020 through 2022



Source and Notes: LMA staff analysis of DES APS case-level data file for fiscal years 2020 through 2022. Emotional abuse was added as a type of abuse to be investigated by DES APS due to enactment of AZ Laws 2022, Chapter 379. According to DES, reports of emotional abuse were not required to be investigated until the summer of 2023 although it did receive these reports before that time. For statutory definitions of types of maltreatment see: <https://des.az.gov/services/aging-and-adult/adult-protective-services/arizona-adult-protective-services-definitions>

DES APS Investigates Whether Vulnerable Adults Have Been Abused, Neglected, or Exploited and Refers Cases to Attorney General’s Office to Determine Substantiation

KEY TERMS

Substantiation indicates that abuse, neglect, or exploitation of a vulnerable adult has occurred. Substantiation decisions include a review of the proposed substantiation by the Attorney General, notification of and right to appeal for the alleged perpetrator, and a final decision by the DES Director. (See Exhibit 3)

The APS Registry is publicly available and contains: the name and date of birth of the person determined to have abused, neglected, or exploited a vulnerable adult and description of the allegation.

If DES APS determines a report meets specific criteria, DES APS initiates an investigation. DES APS staff is statutorily required to investigate the allegation(s) of abuse, exploitation, or neglect (including self-neglect) and determine if a preponderance of evidence exists to substantiate the allegation (see textbox).² DES APS has the authority to investigate allegations that occur in private homes and care facilities. DES policy and procedure also direct DES APS to cross-report to other entities with statutory or regulatory authority to investigate maltreatment, including law enforcement, federal agencies, and state or political subdivision for official purposes, such as ADHS, the DES Long-Term Care Ombudsman, and DES DDD.³

² DES APS Investigation Policy and Procedures, revised 9/24/2022 and Arizona Revised Statutes [A.R.S.] §§ 46-454 (A-D), 46-451 (A) (1-10), [A.R.S.] §§ 14-5101 (3) and A.R.S. 46-452 (A-D).

³ DES APS Central Intake Unit Policy and Procedure Manual, see Chapter 7, Revised 9/24/2022.

As mandated reporters, law enforcement personnel are required to immediately report or cause reports to be made to DES APS if they establish a reasonable basis that a vulnerable adult has been abused, neglected, or exploited. Law enforcement agencies also may conduct criminal investigations alongside or as the result of a DES APS investigation. For example, if the DES APS receives a report about an emergency incident or potential crime, DES policy and procedure direct it to cross-report to the appropriate law enforcement agency. Examples of criminal acts requiring cross-reporting include theft, sexual assault, and emotional or verbal abuse of a vulnerable adult by a caregiver.

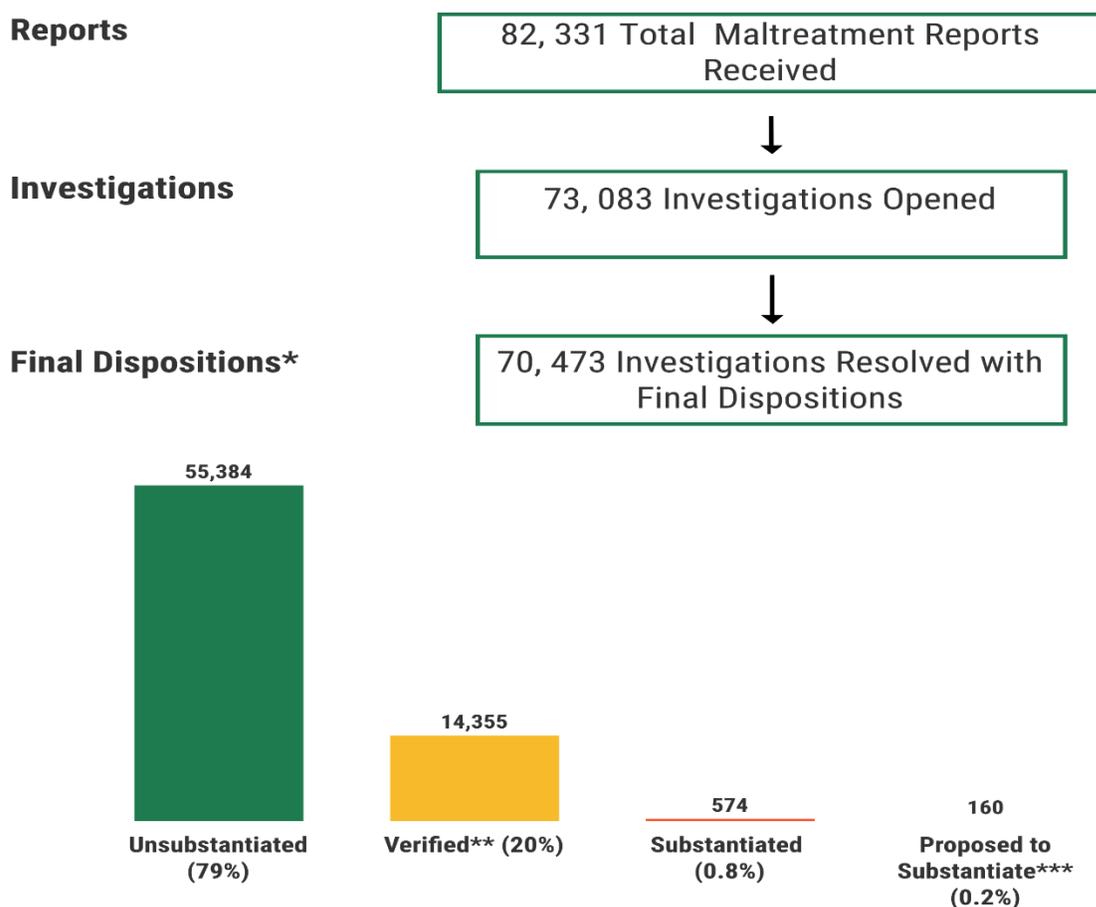
According to policy, DES APS allegations are proposed for substantiation when there is evidence the adult/victim is a vulnerable adult; there is an identified alleged perpetrator; and there is a preponderance of evidence abuse, neglect, or exploitation has occurred. If a DES APS investigator proposes that an allegation be substantiated, a DES APS appeals specialist must review the case before sending it to the Arizona Attorney General's Office for review. The Attorney General's Office is responsible for determining if there is sufficient evidence to support substantiation. If the Attorney General's Office determines there is sufficient evidence to support substantiation, and the perpetrator does not appeal that determination, based on the recommendation from the Attorney General's Office, the DES Director makes a final decision whether the allegation is substantiated and the perpetrator(s) name(s), date(s) of birth, and allegation description are added to the DES APS Registry, which DES APS is responsible for maintaining.⁴

An allegation may be unsubstantiated for several reasons, such as when DES APS determines that an allegation of abuse, neglect or exploitation did not occur, or that there is insufficient evidence that the allegation occurred. Allegations may also be unsubstantiated if DES APS determines that the victim was not a vulnerable adult at the time of the reported abuse, neglect or exploitation.⁵ We determined DES APS' substantiation rate is far lower than the national average and recommend this as an area for further review (see Chapter Five, pages 49 through 55). Exhibit 2 on page 8 presents total reports of maltreatment received by DES APS, investigations opened, and a final case disposition.

⁴ A.R.S. §§ 46-133 and 46-458

⁵ DES APS Central Intake Unit Policy, section CIU-17, revised 9/20/2021.

Exhibit 2. Number of DES APS Maltreatment Reports Received, Investigated, and Results with Final Dispositions Fiscal Years 2020 through 2022



Data Notes:

*The count for final dispositions does not include 2,462 cases that were still open for investigation as of January 23, 2023. There were 148 cases with missing information.

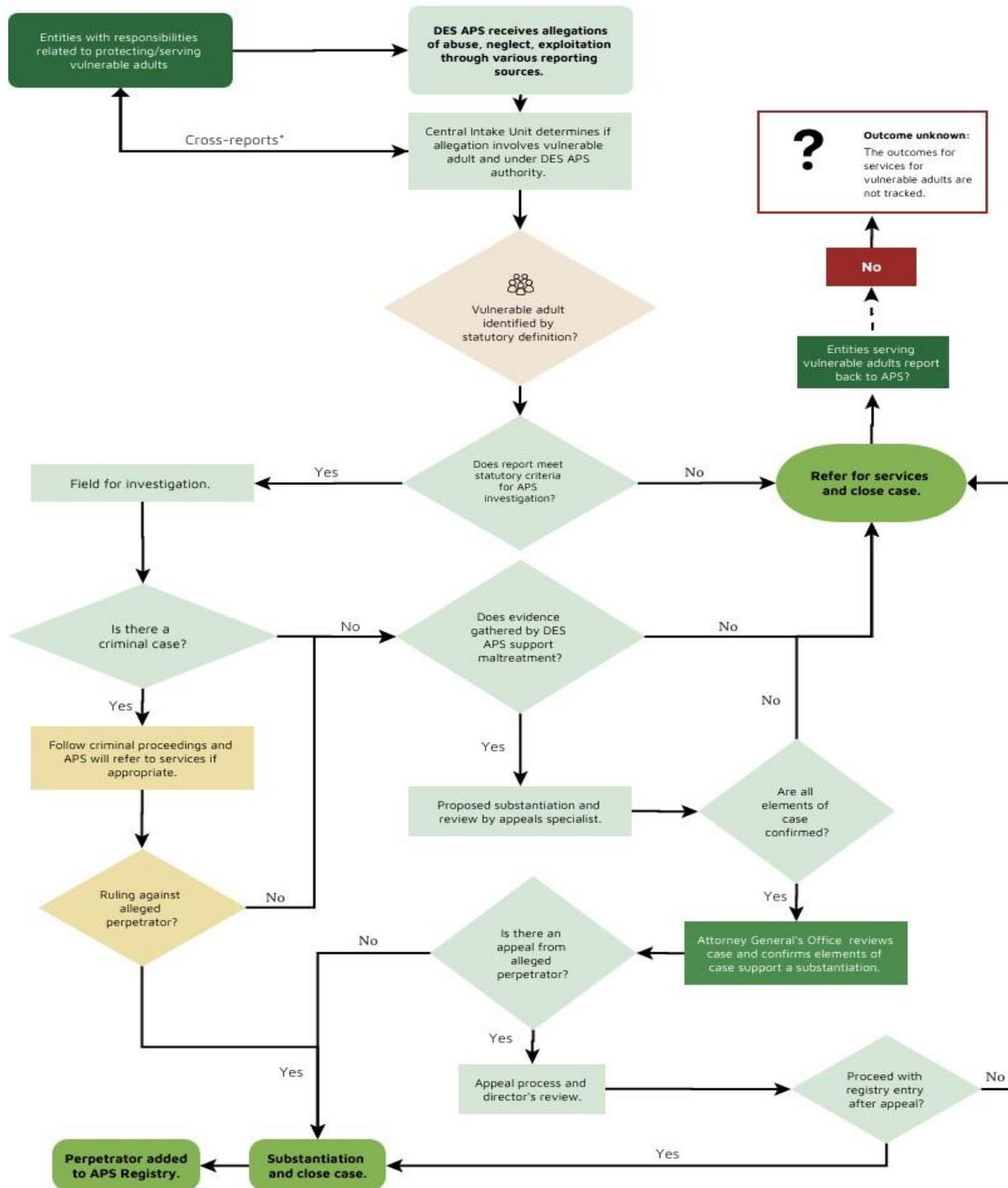
** DES APS verified that maltreatment occurred but did not propose to substantiate the report for various reasons, such as the maltreatment was determined to be self-neglect or it involved a financial scam and no alleged perpetrator could be identified.

***Substantiation decision was still pending as of January 23, 2023.

Source: LMA staff analysis of DES APS Data Dashboard information and case-level data file for fiscal years 2020 through 2022.

The DES APS investigative process is outlined in Exhibit 3 on page 9. Our analysis of DES APS data for fiscal years 2020 through 2022, found its investigation time frame takes longer than its 60-day goal and is higher than the national average. Similar to the lower substantiation rate area, we recommend the investigation time frame area for further review (see Chapter Five, pages 49 through 55, for more information).

Exhibit 3. Flowchart of DES APS Process for Receiving, Investigating and Resolving Vulnerable Adult Maltreatment Reports⁶



Source: LMA staff review of DES APS policies and procedures and flow charts.

⁶ Note that processes related to criminal proceedings indicates DES APS investigator role with local law enforcement and or Office of the Attorney General. DES APS. *Adult Protective Services (APS) Investigation Process Map*. <https://des.az.gov/sites/default/files/dl/AAA-1356A.pdf?time=1688758824695>

DES APS Identifies Services Vulnerable Adults May Need

During an investigation, DES APS staff are required conduct risk, needs, and safety assessment, which involve collecting information regarding a vulnerable adult's safety, physical and mental status, living situation, support system (family and friends), and strengths. Based on a vulnerable adult's needs identified during the investigation, DES APS staff are required to develop a case plan, when they have made contact with the vulnerable adult and preferably with the help of the vulnerable adult or their representative⁷. The case plan must include:

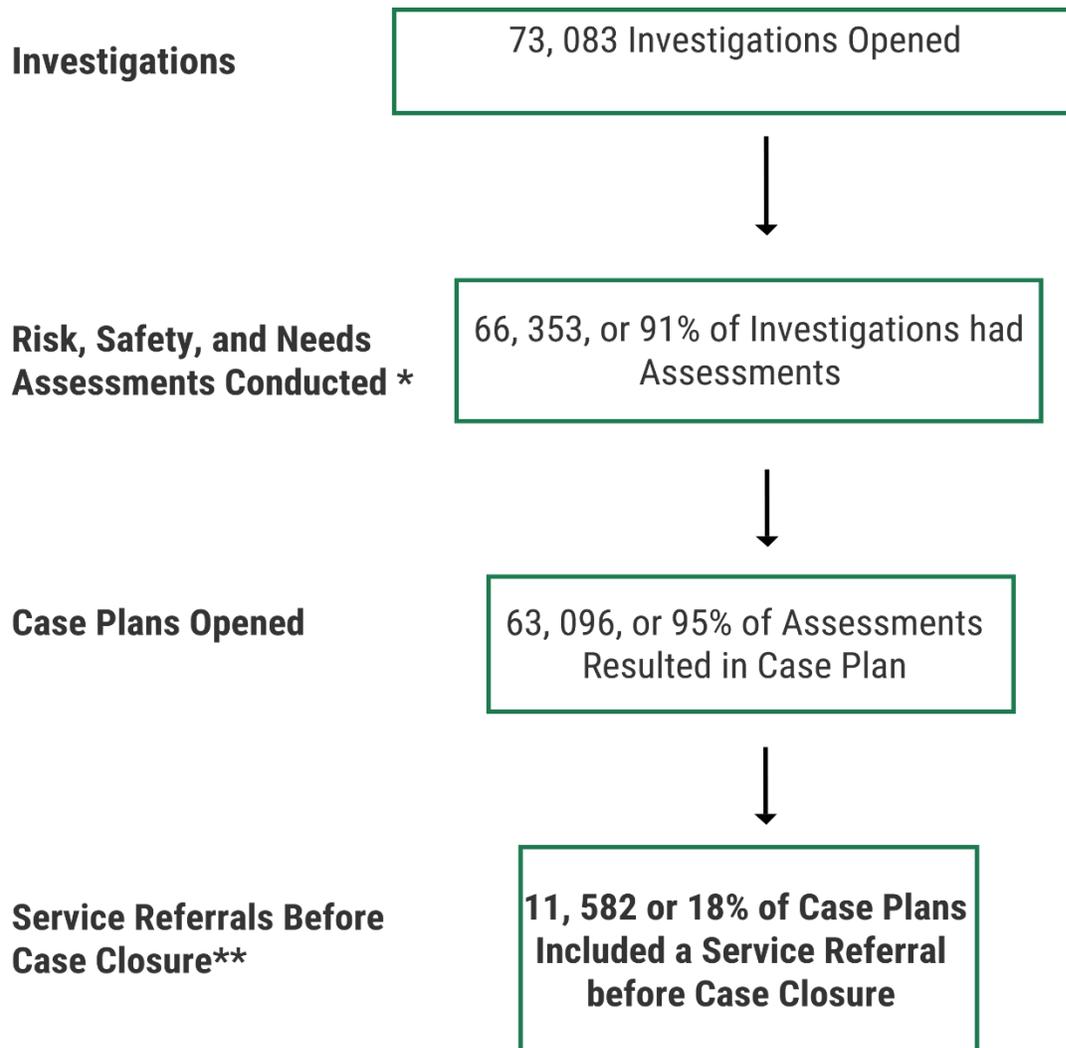
- Risks and plans to mitigate risks and improve safety.
- Timeframes.
- Types of identified services, services offered, and recommended services available for referral.
- Documentation the investigator advised the vulnerable adult of eligibility to receive federal assistance in the forms of services or money.⁸
- List of other individuals involved in case planning.

While DES APS staff do not provide direct services to vulnerable adults, at any point during the investigation, they may refer a vulnerable adult to another entity for services. The DES APS investigator is able to document in the case plan specific details about the service referral. Examples of service categories available for referral include case management, financial, home and community-based services, and behavioral health and medical care. DES policy dictates that DES APS investigators periodically visit an alleged victim/vulnerable adult throughout the course of an investigation to assess the needs of that person. However, as discussed in Chapters 2 and 3 (see pages 22 through 33, and pages 34 through 42), no state agency, including DES APS, has been assigned the responsibility for providing case management for all vulnerable adult cases that DES APS has referred to services during and after an investigation to ensure the vulnerable adults receive the services they need and determine that the services had the desired outcome. Exhibit 4 on page 11 that follows provides information on DES APS case plans and service referrals for fiscal years 2020 to 2022. During this 3-year period, 18% of those vulnerable adults with DES APS case plans had a referral to service before case closure.

⁷ According to DES APS, if the DES APS Investigator is unable to contact the vulnerable adult after at least three in person contact attempts, they will not develop a case plan.

⁸ US Code Title 34 Subtitle II Chapter 201 Victim Rights, Compensation and Assistance. The Victims of Crime Act was passed by Congress in 1984, amended in 1988 and created the Crime Victims Fund, which provides funds to states for victim assistance and compensation programs that offer support and services to those affected by violent crimes. For more information see: <https://ovc.ojp.gov/program/victims-crime-act-voca-administrators/laws-policies>.

Exhibit 4. DES APS Investigations, Assessments, Case Plans, and Referrals to Services Fiscal Years 2020 through 2022



Note:

*Reasons assessments may not be conducted for all investigations opened include that the APS investigator did not contact vulnerable adult after at least 3 in-person contact attempts or if the vulnerable adult was unable to participate in case plan development due to health conditions.

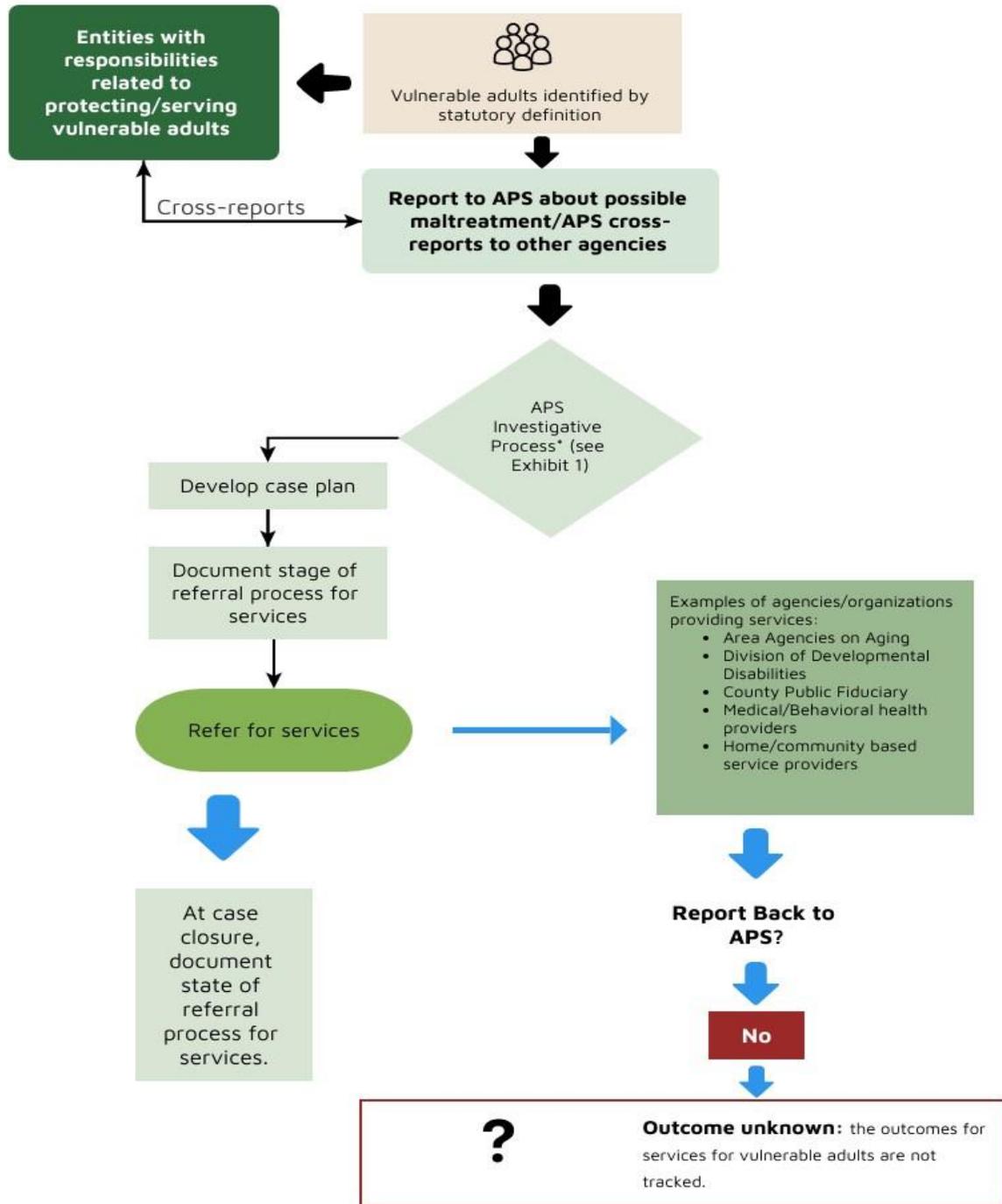
**Vulnerable adults may not be referred for services due to various reasons such as if the vulnerable adult refused services, moved out of state, or was deceased. DES APS does not track the number or types of services it identified for or referred vulnerable adults to, or whether vulnerable adults it referred services to received those services. We identified this as a key gap in Arizona's adult protective services system (see: Chapter 3 pages 34 to 42).

Source: LMA staff analysis of DES APS case-level data file for fiscal years 2020 through 2022.

Outcome of Service Referrals Not Known

Exhibit 5 on page 13 illustrates how services are managed during and after a DES APS investigation. Based on the facts of the allegation, DES APS will cross report to applicable entities such as AHCCCS or ADHS. Likewise, if these entities learn of the potential maltreatment of a vulnerable adult, they may cross report to DES APS. These cross-reports also inform case planning, which is the responsibility of the DES APS investigator. Once a case plan is established, DES APS tracks the status of a service referral until case closure. As previously discussed in this chapter, referrals for services can be made at any time during a DES APS investigation, and other State and community-based agencies may be providing services to vulnerable adults during and after an investigation; however, there is no systematic way to track service access, utilization, and/or benefit. DES APS' current process monitors only the status of service referrals during an open investigation. We identified the need to show service use and impact as a key issue within the adult protective services system in Arizona (see Chapter Three, pages 34 through 42).

Exhibit 5. Flow Chart Depicting Service Process for Vulnerable Adults



Source: LMA review of DES APS policy and procedures.

* At any point during the investigative process, DES APS may be cross-reporting and/or referring to services.

Other Entities Have Important Roles in Arizona’s Protective Services System

Entities providing services to vulnerable adults – Several entities involved in the Arizona adult protective services system provide services or facilitate the provision of services to vulnerable adults. Specifically:

Community Based Area Agencies on Aging – DES APS may refer a vulnerable adult to one of the Area Agencies on Aging (AAA). DES collaborates and coordinates activities; provides program support; and provides technical assistance to AAAs through policies, procedures, and monitoring. DES receives federal funds for the State of Arizona to administer the “Arizona State Plan on Aging” and Older Americans Act services. Federal funds are matched with State funds and allocated to the eight (8) AAAs in contracts based on the intrastate funding formula. DES contracts with the nonprofit AAAs to advocate, coordinate, plan, develop, and deliver services for older adults, people living with disabilities, and their families/caregivers at the local level.⁹ Each AAA covers a specific DES service region (see <https://des.az.gov/services/older-adults/area-agency-on-aging-locations>). Examples of elder and vulnerable adult AAA services include:

- Congregate meals
- Nutrition counseling
- Personal care
- Home-delivered meals
- Adult daycare
- Advocacy
- Family caregiver support program
- Case management
- Community education

AHCCCS – DES APS may refer a vulnerable adult to AHCCCS, the State’s Medicaid program for physical or behavioral health services.¹⁰ AHCCCS contracts with entities known as contracted health plans. These contracted health plans contract with providers, such as physicians and hospitals, to provide healthcare services to AHCCCS members. AHCCCS’

⁹ The federal Older Americans Act provides funding to state level Area Agencies on Aging to advocate for older adults and to offer information on programs, options and community services. Individuals can seek services from AAAs without having to have a service referral from DES APS. For more information about Arizona’s Area Agencies on Aging see: <https://arizonaaging.org/>.

¹⁰ AHCCCS. (2022). Chapter 300 for covered services, Chapter 1200 for ALTCS services, and Chapter 1600 for ALTCS case management. *AHCCCS Medical policy manual*.

focus, unlike DES APS, is not solely related to vulnerable adults. Additionally, adults who are elderly, experience a physical disability, and/or experience a developmental disability may receive services through the Arizona Long Term Care System (ALTCS), a health insurance plan program through AHCCCS. Examples of ALTCS-covered services may include institutional care in a nursing facility; home and community-based services; medical services; behavioral health services; and hospice services.¹¹ Vulnerable adults with a Serious Mental Illness (SMI) designation may access additional AHCCCS services for adults with chronic mental health condition affecting their ability to perform daily activities.¹²

DES Division of Developmental Disabilities – DES APS may refer a vulnerable adult to DES Division of Developmental Disabilities (DDD) for services if they meet DDD program eligibility and could benefit from the services provided. DES DDD is responsible for providing support and services for adults who are diagnosed with at least one developmental disability and show significant limitations in daily life skills due to their qualifying diagnosis in three (3) of seven (7) life skill areas.¹³ DDD contracts with other state and private agencies to provide developmental disability programs and/or services to eligible adults in the State of Arizona.¹⁴ DDD provides the following program services per Arizona Administrative Code:

- Case Management
- Individual Service and Program Plan
- Assignment to Services
- Periodic Evaluations¹⁵

A person receiving DDD services may also be eligible to receive services through ALTCS, in which case DDD reports it works closely with AHCCCS to provide services.

Public Fiduciaries – “Fiduciary” is a term which covers a variety of roles in which individuals serve in positions of trust.¹⁶ DES APS may refer a vulnerable adult to a public fiduciary for services, such as for guardianship if a person is incapacitated, a conservator for persons whose assets need protection, or a personal representative for the administration of a decedent’s estate. Each county in Arizona has a probate court that is part of the State’s superior court system, and the probate court appoints fiduciaries. Persons serving as fiduciaries can be either public or private, but all are licensed by the Arizona Supreme Court, regulated by the Administrative Office of the Courts, and are required to follow virtually identical rules and standards of

¹¹ AHCCCS. (2022). Chapter 1600 ALTCS case management, Policy 1620-O. *AHCCCS Medical policy Manual*.

¹² AHCCCS. (2022). Chapter 300 Medical policy for covered services. *AHCCCS Medical policy manual*.

¹³ See DES DDD guidelines for determining eligibility at <https://des.az.gov/services/disabilities/developmental-disabilities/determine-eligibility>

¹⁴ Arizona Revised Statutes [A.R.S.] § 36-552.

¹⁵ Arizona Administrative Code. Title 6, Chapter 6, Article 6 (R6-6-601 - 604).

¹⁶ Arizona Fiduciaries Association. <https://www.azfid.org/page-1750901>.

practice, with a few minor exceptions. Statute requires DES APS to refer vulnerable adults to a probate court for consideration of fiduciary services, which then opens an investigation by the court into the need for fiduciary services.¹⁷ Stakeholder interviews and information provided by DES APS for our review indicated this area should be considered for further review. One issue is that unlike some other states, DES APS does not have the authority to establish temporary fiduciary services, which can prevent important services from being quickly implemented (see Chapter Five, pages 49 through 55, for more information).

Some State agencies involved in Arizona’s adult protective services system also conduct investigations related to allegations of vulnerable adult maltreatment – State agencies responsible for conducting investigations related to their specific statutory responsibilities include:

ADHS – ADHS may conduct its own investigations related to allegations of vulnerable adult maltreatment in a facility it licenses but focuses on whether a licensing violation has occurred. If DES APS receives a report on a vulnerable adult who is residing in a facility licensed by ADHS, DES APS must cross-report that concern to ADHS.¹⁸ ADHS is responsible for licensing and regulating facilities including long-term care, medical health care, residential health care, or special licensing institutions that often house and/or provide care for vulnerable adults.¹⁹ A specific ADHS bureau oversees each facility type. For example, the Bureau of Long-Term Care Facilities Licensing oversees entities such as nursing homes, intermediate care facilities for individuals with intellectual disabilities, and nursing-supported group home facilities. The Bureau of Medical Facilities Licensing oversees entities such as medical health care institutions and medical service providers such as hospitals, home health agencies, and surgery centers.

ADHS does not facilitate, coordinate, or provide direct services to vulnerable adults. Rather, ADHS’s licensing bureaus have responsibility for and the authority to inspect licensed facilities and to receive and investigate complaints related to those facilities. ADHS complaint investigations do not focus on the vulnerable adult if one is the subject of a complaint, but rather on determining if the facility committed any regulatory violations that can be substantiated. Any facility-related complaints can be submitted through an online complaint portal specific to the type of facility.

After receiving a complaint, ADHS policy directs that ADHS must review the intake to determine if it contains allegation(s) of a licensed facility's noncompliance with licensing regulations then assign priority based on the scope and severity of allegation(s).²⁰ The priority

¹⁷ Arizona Revised Statutes [A.R.S.] 14-5602.

¹⁸ ADHS also receives reports from other sources besides DES APS and is also required to cross-report any allegations of adult abuse, neglect or exploitation to DES APS.

¹⁹ See: <https://www.azdhs.gov/licensing/index.php>

²⁰ If the intake does not include allegation(s) of noncompliance with a licensing regulation, ADHS policy directs that it will be closed out due to the absence of regulatory authority by ADHS.

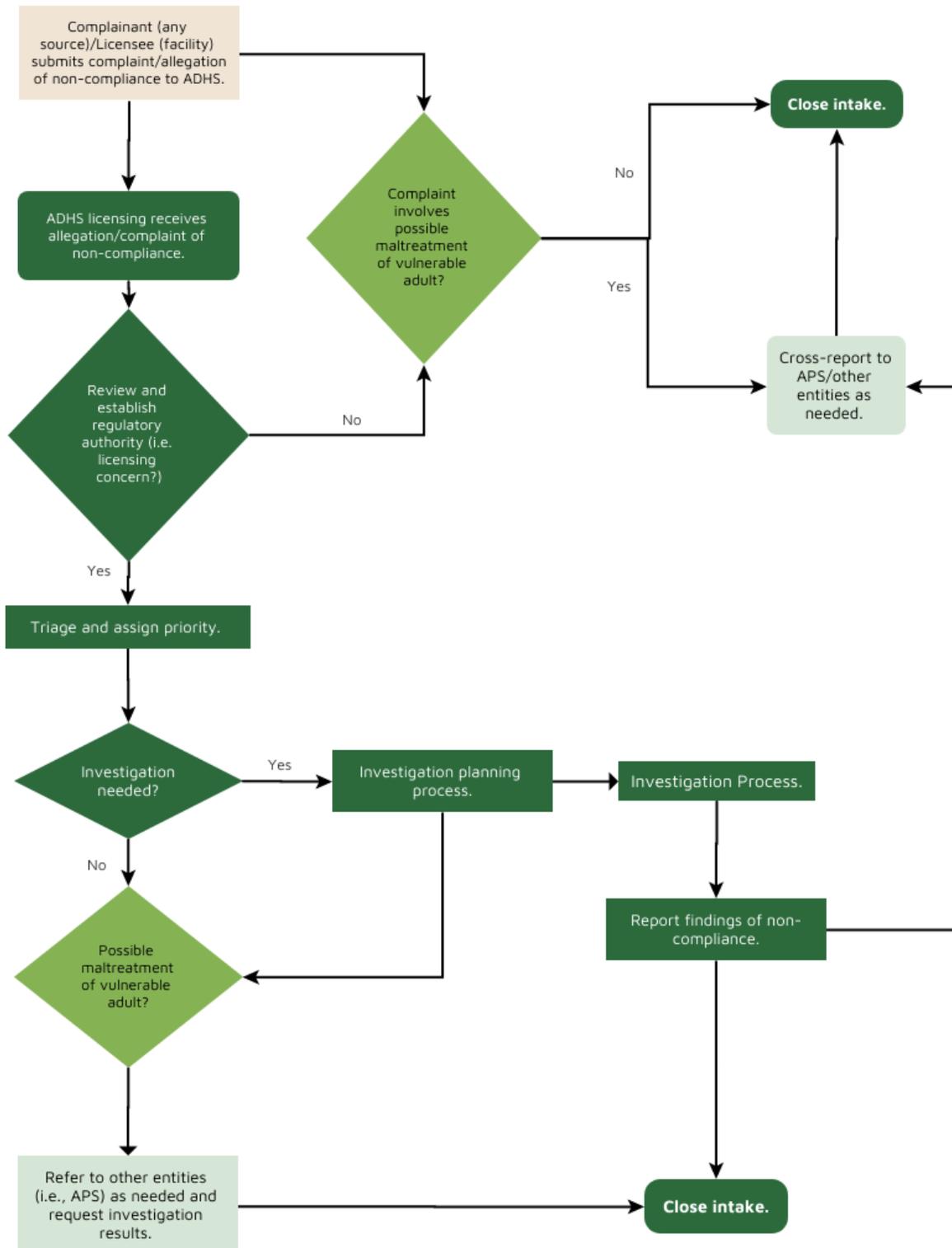
level determines how quickly ADHS must begin investigating the complaint. ADHS must provide facilities with a Statement of Deficiencies and the facilities are required to produce a Plan of Correction to address the Statement of Deficiencies. ADHS is then responsible for reviewing the Plan of Correction and determining if the facility appropriately addresses and corrects deficiencies. ADHS is required to report facility non-compliance to the Centers for Medicare and Medicaid Services (CMS) for those facilities covered by CMS.²¹

Employees at ADHS licensed facilities are considered mandated reporters (see page 5 for a definition), and are required to report to a peace officer or DES APS directly if they have a reasonable basis to believe that abuse, neglect, or exploitation of a vulnerable adult has occurred.²² In addition, ADHS reported that if ADHS finds during its investigative process a facility has not reported a concern of potential maltreatment of a vulnerable adult it will direct the facility to do so and may cross-report to DES APS (see Exhibit 6, following on page 18, for an overview of the ADHS Complaint Investigation Process for Licensed Facilities Which May Involve a Vulnerable Adult).

²¹ According to ADHS, it does not report results of facility investigations to DES APS.

²² ARS §46-454.

Exhibit 6. ADHS Complaint Investigation Process for Licensed Facilities Which Could Involve Incidents of Maltreatment of Vulnerable Adults



Source: LMA staff review of ADHS policies and procedures and flow charts.

AHCCCS – AHCCCS also conducts its own investigations, which may be related to an allegation of vulnerable adult maltreatment involving an AHCCCS member; specifically, any concern of AHCCCS members and community members that may involve abuse or neglect can be submitted to the individual provider, health plan, or AHCCCS. AHCCCS and health plan staff are responsible for reviewing and evaluating member and provider concerns, and determining if the concern is a Quality of Care (QOC) concern. A QOC concern is an allegation that any aspect of care, treatment, utilization of behavioral or physical health services that caused or could have caused an acute medical/psychiatric condition or exacerbation of a chronic medical/psychiatric condition and may ultimately cause the risk of harm to an AHCCCS member.²³ AHCCCS policy directs that both AHCCCS and the health plans receive QOC referrals from internal and external sources. When AHCCCS receives a referral, its Quality Management (QM) unit triages the referral and if a potential QOC review is determined to be warranted, AHCCCS QM will send the referral to the respective health plan to complete an investigation or complete the investigation directly for fee-for-service (FFS) members. Per AHCCCS policy, all QOC complaints must be addressed and accompanied by documentation in the AHCCCS QM Portal explaining the investigation and resolution, including applicable referrals to regulatory agencies.²⁴

In addition, health plan staff are responsible for submitting QOC concerns including reports of possible abuse, neglect, or denial of rights involving any behavioral health provider serving members with a SMI determination or anyone under court order for evaluation or treatment to the Independent Oversight Committee (IOC) per AHCCCS policy. The IOC is overseen by the Arizona Department of Administration and per statute is responsible for reviewing incidents of possible abuse, neglect, or denial of vulnerable adult's rights and making recommendations to the director of the Arizona Department of Administration and the Arizona Legislature to ensure the protection of vulnerable adults receiving behavioral health and developmental disability services.²⁵ Per AHCCCS policy, the IOC review is completed at the conclusion of the investigation. The health plans submit a redacted report to the IOCs for review and the IOC must identify if the QOC concern is an IOC concern, determine if it involved a rights violation, and submit their objection or finding to the Arizona Department of Administration for referral to the agency director (see Exhibit 7, page 20, depicting an overview of investigation process).

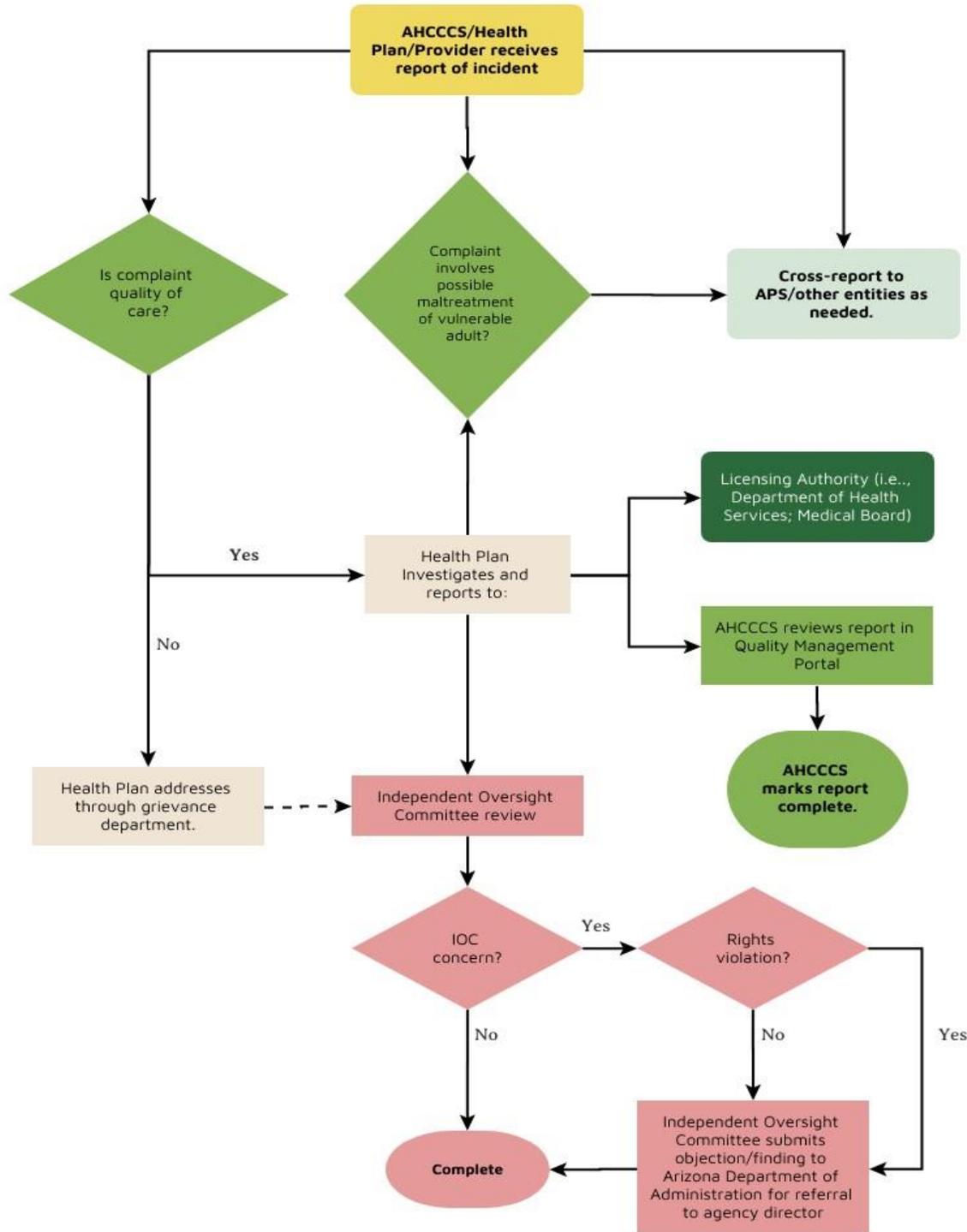
²³ AHCCCS. *Contract and Policy Dictionary*.

<https://www.azahcccs.gov/Resources/Downloads/ContractAndPolicyDictionary.pdf>

²⁴ AHCCCS. (2022). Chapter 900 Quality management and performance improvement program, policy 960. *AHCCCS Medical policy manual*.

²⁵ Arizona Revised Statutes [A.R.S.] §§ 41-3801 through 41-3804.

Exhibit 7. AHCCCS QOC and IOC Investigation Processes Which May Involve Maltreatment of a Vulnerable Adult



Source: LMA staff review of AHCCCS policies and procedures and flow charts.

DES Division of Developmental Disabilities (DDD) – DES DDD cross-reports allegations to DES APS and in addition may conduct its own investigations related to vulnerable adults. Specifically, if DES APS receives an allegation for an adult who is reported to be receiving DDD services, it must cross report to DES DDD. In addition, if DES APS receives a report involving a DDD member who is enrolled in AHCCCS/ALTCS, it must cross-report to AHCCCS. The DES DDD Quality Management Unit (QMU) is directed by DES policy and procedure to investigate 3 types of incidents involving DDD members: a Quality-of-Care concern, a systemic concern that is defined from tracking that indicates an issue in the overall system, or a sentinel event which is defined as an unexpected event that results in the death or serious physical / psychological harm / injury of a member. DDD coordinates its investigation with other agencies including DES APS and may delay its investigation if an external agency initiates its investigation to avoid conflicts. When DES DDD’s investigations involve an AHCCCS or ALTCS member, findings are placed in the AHCCCS QM Portal.²⁶

DES Long-Term Care Ombudsman Program – The DES long-term care ombudsman program does not provide services to vulnerable adults but focuses on assisting, advocating, and intervening on behalf of a long-term care facility resident after receiving a complaint.^{27,28} DES employs a Long Term Care Ombudsman that works in its Phoenix office and also contracts with community-based AAAs to provide a long-term care ombudsman program, see information about AAAs on page 14. The DES ombudsman program staff role includes providing education about long-term care issues and services to residents, families, and facility staff; promoting and advocating for resident rights; providing assistance to obtain needed services; and working with family and resident councils.²⁹ Staff who work in the DES ombudsman program are not mandated reporters but encourage residents to report incidents or allegations of maltreatment to DES APS. Per DES policy, the role and responsibility of the DES ombudsman program in the complaint resolution process is to support and maximize resident participation including discussing the complaint with the resident to determine the wishes of the resident, advising residents of their rights, working with the resident to develop a plan of action to resolve the complaint, and determining whether the complaint is resolved to the resident’s satisfaction.

²⁶ DES Division of Developmental Disability. (2021). Chapter 6000, 6002-F Investigative process. *Division of Developmental Disabilities Medical policy manual*.

²⁷ DES Division of Aging and Adult Services. Chapter 3000, 3700 Long-term care ombudsman program. DES Division of Aging and Adult Services: Policy and procedure manual. <https://des.az.gov/LTCOP>.

²⁸ Arizona Revised Statutes [A.R.S.] §46-452.01.

²⁹ Family councils are a group of family members in a long-term facility who communicate concerns to facility administrators and work for improvements. Resident councils consist of long-term care facility residents meeting to provide input about their care to the facility (*The national long-term care ombudsman resource center*. <https://ltcombudsman.org/issues/family-and-resident-councils#ex>).

CHAPTER TWO - STRATEGIC DIRECTION

Legislative Request:

Examine the current adult protective services system and consider best practices to improve the delivery of service in this state, including developing a strategic direction that ensures the safety of vulnerable adults and establishes protocols for services after an investigation.

Conclusions:

Although we did not identify a specific strategic approach for adult protective service systems, our literature review and expert consultant review identified components that would be important for any adult protective services system, including targeting systems beyond just the individual victim, such as the perpetrator, to help alleviate mistreatment risk, known as having an ecosystems perspective, and focusing on specific outcomes, such as providing services during and after an investigation and reducing revictimization. We did not identify a documented strategic direction for Arizona's adult protective services system. Additionally, we identified some gaps in Arizona's adult protective services system relative to these components, including that no state agency has the responsibility for managing vulnerable adult cases after a DES APS investigation to ensure that vulnerable adults receive the services they need and there are no processes for assessing whether services provided during or after an investigation to vulnerable adults are alleviating mistreatment. Several other states are beginning to implement aspects of ecosystems approaches and other important components, including protocols for providing services after an investigation and processes for measuring and reporting on vulnerable adult outcomes. DES, including APS, given its responsibilities related to vulnerable and older adults, should work with the Governor, President of the Arizona Senate, and Speaker of the Arizona House of Representatives to establish and appoint members to a working group to develop a strategic direction for Arizona's adult protective services system that incorporates the components we identified and considers the approaches being implemented by other states.

Experts Promote a State Adult Protective Services System with an Ecosystems Perspective Focused on Vulnerable Adult Centered Outcomes

Although we did not identify a specific strategic approach for adult protective service systems, our literature review and expert consultant review identified key focus areas that would be important for Arizona’s adult protective service system. Specifically:

- **An Ecosystems Perspective**—In 2003, the National Research Council promoted using an ecosystems perspective to understand and respond to elder mistreatment.³⁰ This perspective is based on the idea that mistreatment and risk of revictimization is influenced by several factors and responding to the mistreatment of elder, vulnerable adults means targeting systems beyond just the individual victim to alleviate mistreatment risk.³¹ Using this perspective, a strategic direction intended to ensure the safety of vulnerable adults must be based on an understanding that elder abuse is an issue affected by several levels of ecological influence, including the individual victim, individual perpetrator, victim-perpetrator relationship, and the surrounding social environment.³² For example, a strategic approach using this perspective targets systems beyond the individual victim to alleviate mistreatment risk, such as interventions that integrate the perpetrator and the larger family system or that seek to alter the home living environment and broader social network.
- **Specific Outcome Results**—Experts in the elder mistreatment arena recommend that adult protective services result in the following outcomes:
 - (1) reduced elder and vulnerable adult mistreatment (i.e., harm reduction) and reduced recurrence, that is, adult protective services vulnerable adults returning to adult protective services due to additional victimization / self-neglect for investigation after their cases have been closed;
 - (2) service or case plans that are tailored to each victim’s goals and needs (i.e., vulnerable adult centered); and
 - (3) vulnerable adults engaging in services during and after an investigation that alleviate mistreatment.³³

³⁰ National Research Council. (2003). *Elder mistreatment: Abuse, neglect, and exploitation in an aging America*. Washington, DC: The National Academy Press.

³¹ Burnes, D. (2017). *Community elder mistreatment intervention with capable older adults: Toward a conceptual practice model*. *The Gerontologist*, 57(3), 409-416. doi:10.1093/geront/gnv692.

³² Burnes, D., MacNeil, A., Nowaczynski, A., Sheppard, C., Trevors, L., Lenton, E., Lachs, M. S., & Pillemer, K. (2021). *A scoping review of outcomes in elder abuse intervention research: The current landscape and where to go next*. *Aggression and Violent Behavior*, 57, 101476. doi:10.1016/j.avb.2020.10147

³³ Liu, P., Hass, Z., Stratton, S., Conrad, K. and Conrad, K. (2022) *Examining Adult Protective Service Outcomes: Services Associated with the Decrease of Mistreatment Differed by Elder Mistreatment Type*. *Gerontologist*, vol. 62, no. 9, 1359-1368. <https://doi.org/10.1093/geront/gnac040>.

Managing Services During and After an Investigation – National Adult Protective Services Association (NAPSA) standards state that the goal of a service or case plan is to make the vulnerable adult client safer, prevent continued abuse, and improve his/her quality of life. At case plan closure, NAPSA standards indicate that there should be documentation of the service interventions, their outcomes, and an assessment of their efficacy for the vulnerable adult.³⁴ For this review, consideration was given to the creation of a single state agency as a means to better serve vulnerable adults through centralization of investigative and service functions. However, the expert consultants on our team did not recommend for the State of Arizona to create a free-standing, or independent state agency to provide adult protective services. The primary reasons for this recommendation include that establishing a new agency could result in significant costs, and that even if Arizona created an independent adult protective services agency, that agency would still need to make referrals to and collaborate with, numerous other state and private entities to fully meet the needs of vulnerable adults in need of protection. The consultant indicated that improvements can be made to the existing Arizona adult protective service system in order to serve vulnerable adults experiencing abuse and neglect more efficiently and effectively.

Arizona Lacks Overall Strategic Direction for System

Although we reviewed several documents, we did not find amongst any of the three state agencies, DES, AHCCCS, or ADHS, written documentation of a strategic direction for Arizona’s adult protective services system.³⁵ For example, DES’ Division on Aging and Adult Services, created the 2023 – 2026 Arizona State Plan on Aging, but this plan’s focus is on dealing with the many issues of aging in Arizona, not Arizona’s adult protective services system. Although this plan includes an objective related to elder maltreatment, its strategies are primarily centered on public awareness and training initiatives. This objective does not establish an overall strategic direction for the adult protective services system to serve vulnerable adults.³⁶ In addition, DES APS produced a state plan in March of 2020, with 4 goals and 9 recommendations for improving the adult protective services system in Arizona.³⁷ This plan was developed through collaborative meetings with stakeholder groups. The plan’s goals included streamlining resources for investigations and substantiation and increasing awareness and access to community resources. While this plan established important goals and recommendations, it

³⁴ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*. <https://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf>.

³⁵ See Appendix B – Methodology (pages 57 through 60) for the various documents included in our review.

³⁶ See DES Division of Aging and Adult Services. (2022). *Arizona state plan on aging (2023-2026)*. As a part of receiving federal funds, the federal Older Americans Act requires each State Unit on Aging, which DES has been designated as, to submit a state plan every 4 years to the U.S. Department of Health and Human Services, Administration for Community Living.

³⁷ DES, ADHS. (2020). *DES APS Action Plan* (March 2020).

focused primarily on gaps within DES APS' processes, and not the adult protective services system as a whole.

Similarly, we reviewed reports produced by the Abuse & Neglect Prevention Task Force (see Appendix A for more information on the Task Force). This task force was created in 2019 in response to Executive Order 2019-03, which acknowledged that vulnerable populations are at increased risk of abuse and exploitation and these populations include individuals with disabilities. The Executive Order directed the task force to make recommendations that would further protect and improve care for individuals with disabilities in Arizona. Although this task force did not develop a specific strategic direction for Arizona's adult protective services system, several of its recommendations were aimed at improving the overall adult protective services system. For example, the task force recommended developing a statewide public awareness campaign related to identifying and reporting abuse, neglect, and exploitation of vulnerable adults and conducting a review of the AHCCCS and DES websites and make any necessary changes to facilitate public access to incident data on abuse and neglect of vulnerable adults.

System Gaps Related to Recommended Strategic Approach Exist

We identified gaps in Arizona's adult protective services system related to three of the four recommended areas: (1) reducing maltreatment and reducing recurrence or re-victimization; (2) vulnerable adults engaging in services during and after an investigation that alleviate mistreatment; and (3) providing case management services.

Unclear whether or extent to which agencies' services are reducing mistreatment and re-victimization. As indicated in Chapter One, DES APS is the only agency with the authority and responsibility to investigate specific allegations of abuse, neglect, self-neglect, and exploitation of a vulnerable adult. ADHS investigates to determine if a licensed facility committed a licensing violation and AHCCCS investigates whether contracted health plans have met quality standards for providing physical health and behavioral services for eligible members. However, there is no mechanism for collecting information on how services and resources from all three agencies are alleviating the effects of mistreatment for a vulnerable adult during or after an investigation and preventing re-victimization of vulnerable adults in Arizona's adult protective services system (see Chapter Three, for more information on lack of data).

System lacks protocols for services after an investigation and providing case management.

The goal of DES APS case planning is “to evaluate allegations and offer service referrals as necessary to resolve abuse / neglect / exploitation of vulnerable adults”.³⁸ While focused primarily on mitigating risks and improving safety, case planning involves referring vulnerable adult individuals to other agencies and community-based providers for direct services. No state agency, including DES APS, has been assigned the responsibility for providing case management for all vulnerable adult cases that DES APS has referred to services during and after an investigation to ensure the vulnerable adults receive the services they need and determine that the services had the desired outcome.³⁹

It is important to note that DES APS’ primary focus on mitigating risks and improving safety is similar to other states. Often adult protective service programs do not provide ongoing case management services but are designed as an emergency and short-term program. One reason for this narrowly focused structure is that there is no dedicated federal funding for state adult protective services, forcing states to look to multiple sources for funding and often leaving states with inadequate resources for their adult protective service programs.⁴⁰ Research and policy experts share the view that often state adult protective service systems are not funded in a manner, for example, to attempt to provide ongoing case management to all of the vulnerable adults about whom they receive reports.

Despite these financial challenges, unlike Arizona, many states have begun to provide services to vulnerable adults post-investigation until on-going services commence work with the vulnerable adult; see examples on pages 28 to 30.⁴¹ The national consultants on our team also noted that many states are moving towards providing or facilitating post-investigation services and the National Adult Protective Services Association (NAPSA) reported on similar efforts as early as 2016.⁴²

³⁸ DES APS Investigations Policy and Procedure Manual, Chapter 12, September 2022.

³⁹ DES reported that some vulnerable adults it refers for services may receive case management type services from other agencies, such as case management services associated with behavioral health services, but acknowledged that there is no system-wide case management for vulnerable adults DES APS has referred to services to alleviate the effects of maltreatment.

⁴⁰ National Voluntary Consensus Guidelines for State Adult Protective Systems (March 2020). Administration for Community Living, Office of Elder Justice and Adult Protective Services, US DHHS, Washington, DC.

⁴¹ DES APS does not currently have a program that provides services to vulnerable adults post-investigation. However, subsequent to our review, DES reported launching a care coordination initiative in July 2023 that centralized staffing and coordination of services for self-neglecting individuals and helped to identify treatments for bed bugs, hoarding, and biohazard cleanups.

⁴² Quinn, K., Ramsey-Klawnsnik, H., Capehart, A. (2016) *Lessons Learned from Research and Practice: An APS Technical Assistance Report Part II- Innovative Practices from the Field*. National Adult Protective Services Resource Center.

Protocols for Services after an Investigation Important for Reducing Maltreatment and Revictimization

As mentioned above, there are significant efforts underway in some states (see next section, pages 28-30) to shift strategy to include service provision after an investigation. The reasons for this include:

- Effective services can prevent vulnerable adults from suffering further threats to human dignity and safety, i.e., additional physical abuse, emotional abuse, neglect, self-neglect and or exploitation.^{43 44}
- Effective services can prevent an adult from re-entering the adult protective services system due to maltreatment issues not resolved. Recent published research using California APS administrative data indicated that 20% of reports were recurrent within one year after baseline closure. Self-neglect being the most common type of report to recur (14.3%) and overall recurrence was predicted by female gender, older age, living alone, and multiple elder abuse, neglect, and exploitation types reported at baseline.
- Effective services can lessen the health care costs involved in serving older and vulnerable adults as research has demonstrated that those who have experienced even modest forms of maltreatment have higher (300%) morbidity and mortality rates and higher rates of emergency department use, hospitalization, readmission, skilled nursing placement, and hospice use compared to those who have not experienced maltreatment.

⁴³ Lewis, S., Connolly, MT., Salvo, E., Kimball, PF., Rogers, G., MacNeil, A., and Burnes, D. (2023). Effect of an Elder Abuse and Self-Neglect Intervention on Repeat Investigations by Adult Protective Services: RISE Project. *Journal of the American Geriatrics Society*, see: <https://doi.org/10.1111/jgs.18506>

⁴⁴ Rowan, J.M., Yonashiro-Cho, J., Wilber, K.H., Gassoumis, Z.D. Who is in the revolving door? Policy and practice implications of recurrent reports to adult protective services. *J Elder Abuse Negl*. 2020 Nov-Dec; 32(5):489-508. doi: 10.1080/08946566.2020.1852142. PMID: 33308080.

Several States are Beginning to Implement Ecosystems Approaches, Protocols to Ensure Services after an Investigation and Processes for Measuring and Reporting on Vulnerable Adult Level Outcomes

Some states and lesser jurisdictions are beginning to implement what is referred to as state Adult Protective Services to Community Services Transition strategies. These are programs that allow for state adult protective services agencies to better support vulnerable adults during and after an investigation by assisting adults to engage in services in their community. Based on: (1) an understanding that elder abuse is an issue affected by several levels of ecological influence, including the individual victim, individual perpetrator, victim-perpetrator relationship, and the surrounding social environment; and (2) that services need to be vulnerable adult centered and result in alleviating mistreatment, preventing recurrence of abuse, exploitation and or neglect / self-neglect. The following examples identified in this review are provided to inform about several community service transition initiatives recently funded by the federal Administration for Community Living.⁴⁵

Maine - RISE In 2018, Maine began using the RISE intervention model. This model is a cross-sector partnership between Maine’s Department of Health and Human Services, Office of Aging and Disability Services, Adult Protective Services program and a community-based nonprofit organization with a goal of enhancing services provided and outcomes in cases of adult maltreatment complicated by substance use. Under this model, the APS worker completes the investigation and substantiation phases of case work and may facilitate certain state-sanctioned processes (e.g., guardianship, application for certain benefits, and medical evaluations), while the RISE advocate, housed within a community-based organization, is responsible for implementing the direct practice key processes and core components of the RISE intervention model. This differs somewhat from Arizona protocols whereby a referral to services is made instead of service management happening concurrently. The RISE model, informed by an ecological-systems perspective, focuses its interventions on the victim, the harmer, their relationship, and community to address the elder abuse risk and strengthen the supports surrounding the victim-harmer dyad. Early research results indicate that RISE was associated with a significantly lowered likelihood of recurrence compared to persons receiving usual care provided by APS.⁴⁶

New York In 2021, Lifespan of Greater Rochester Inc., a regional nonprofit community-based organization serving older adults, and project partners are piloting a model of co-locating an aging service care manager with APS staff at one location, for on-site consultation and joint assessment of vulnerable adults to facilitate access to the full array of Area Agency on Aging type services (funded under the federal Older

⁴⁵ These examples were either identified by the national experts on our team and or through literature reviews and interviews with other state adult protective service system professionals. Particularly important resource is the federal Administration for Community Living, Elder Justice Innovation Grants on Transitions from APS to Community Services. For more information about these ACL programs, see: <https://acl.gov/news-and-events/announcements/new-elder-justice-grants-address-aps-training-guardianship-aps>.

⁴⁶ See: <https://academic.oup.com/gerontologist/article/63/6/966/6608975>

Americans Act) and other community services. This type of co-location staffing is not happening in Arizona. Intensive care management is provided by Lifespan once the crisis that prompted a referral to APS is stabilized. According to the program manager at Lifespan, the co-location of a case manager employed by a community agency is intended to make the process of providing services during and after an investigation more seamless in nature. Based on early results, this model has received an additional \$230,000 in funding for 2024.

Missouri APS Direct Services Program In 2022, Missouri began implementing a case management system with the intent of improving referrals and services for its APS vulnerable adult. Similar to Arizona, once Missouri APS staff determines that interventions are needed for which there is no state Missouri APS funding, they then refer the vulnerable adult to the network of Area Agencies on Aging (AAAs). However, Missouri’s approach has several key differences from Arizona. First, Missouri uses a case management system to make its referrals. Additionally, AAA staff or subcontractors then engage with the APS vulnerable adult to provide case management services and coordinate setting up the other services and goods in the individual’s case plan. If additional needs are identified, AAA staff seeks approval from APS to provide the additional interventions if deemed necessary. Finally, once the services are delivered or the goods are obtained, AAA staff completes a satisfaction survey with the vulnerable adult, reports the outcomes of their case actions to APS via the system, and invoices the Department for reimbursement of their expenses from federal American Rescue Plan Act funding directed towards this program.

Utah In 2021, the Benjamin Rose Institute on Aging (BRIA), a nonprofit focused on supporting caregivers, began collaborating with Utah APS and the Utah Association of Area Agencies on Aging to develop, implement, and evaluate an innovative practice addressing caretaker neglect and to provide services and resources to alleged victims and perpetrators. The goal of this project is to develop a practice to coordinate care beyond APS case closure as well as to demonstrate improvements in physical health, emotional health, function, and social support for alleged victims and perpetrators. Current practice in Arizona does not coordinate care or services after an investigation. BRIA will guide practice, policy, and future research on caretaker neglect and poly-victimization (multiple forms of victimization) by providing evidence to Utah APS and the federal grant funder, ACL on maltreatment, needs/challenges, services, and outcomes for victims and perpetrators. ACL projects include an evaluation process to report on the progress of implementation and outcomes.

Pennsylvania, Allegheny County In 2022, the Allegheny County Department of Human Services, Area Agency on Aging (DHS/AAA) plans to implement “Pathways to Safety” (Pathways), a scalable, collaborative intervention between state and County adult protective service workers and staff from a regional Area Agency on Aging. Pathways aims to prevent persons who are age 60 and older who have experienced abuse from re-victimization. This intervention strives to achieve this goal by leveraging data- and practice-based evidence of effective services. Pathways’ objectives are: (1) to implement a stronger support system that will preserve older adults’ independence and mitigate risk of recurrent abuse by improving older adults’ access to services in areas of need, including food insecurity, physical health, activities of daily living and social isolation, and (2) to measure and evaluate the Pathways system. The second objective, through measurement and evaluation will be to (a) leverage research partnerships, (b) document effective programming, and (c) use data for making determinations of best practices and lessons learned. Additionally, cost savings outcomes will be evaluated.

Iowa	The Iowa Department on Aging is currently assessing the various community services that produce better outcomes for persons transitioning from Iowa state APS interventions and programs to community-based programs that remediate and prevent recurrence of abuse over the longer term. The project will include the creation of a coordinated referral process to assist in prevention efforts. This project is a federal ACL funded project and is required to produce annual evaluation reports that are publicly available. The first report is due to be completed in calendar year 2023.
California	The Community Service Agency based in Stanislaus County, California, seeks to improve systems and responses to older adults and adults with disabilities with substantiated cases of self-neglect, neglect, financial and physical abuse. This includes coordinating among community-based partner agencies and Older Americans Act programs. Enhancements will be made to evidence-informed and practice-informed services, strategies, advocacy, and interventions for APS vulnerable adults to ensure they achieve long-term measurable improvements in health, social, and functional status; preserve their autonomy and independence; and mitigate the risk of recurrent abuse. This project is a federal ACL funded project and is required to produce annual evaluation reports that are publicly available. The first report is due to be completed in calendar year 2023.

DES Best Positioned to Lead on Establishing Strategic Direction for Arizona’s Adult Protective Services System

DES, including APS, given its responsibilities related to vulnerable and older adults, is best positioned to lead the effort to establish a strategic direction for Arizona’s adult protective services system. Specifically:

- DES APS’ primary role is investigating abuse, neglect, and exploitation, and identifying service needs and referring vulnerable adults for services.
- DES APS’ participation in the National Adult Maltreatment Reporting System (NAMRS), and its efforts to develop and implement a public facing data dashboard.⁴⁷
- DES’ authority to develop and administer the Arizona State Plan for Aging, in accordance with the federal Older Americans Act.⁴⁸

To help ensure that Arizona develops an effective strategic direction, DES should work with the Governor, President of the Arizona Senate, and Speaker of the Arizona House of Representatives to establish and appoint members to a working group to develop a strategic direction for Arizona’s adult protective services system. When recommending working group

⁴⁷ The National Adult Maltreatment Reporting System (NAMRS), of the federal Department of Health and Human Services, Administration for Community Living, is the first comprehensive, national reporting system for adult protective services (APS) programs. It collects quantitative and qualitative data on APS practices and policies, and the outcomes of investigations into the maltreatment of older adults and adults with disabilities. The goal of NAMRS is to provide consistent, accurate national data on the exploitation and abuse of older adults and adults with disabilities, as reported to APS agencies.

⁴⁸ See: <https://acl.gov/about-acl/authorizing-statutes/older-americans-act>

members the Governor’s Office, President of the Arizona Senate, Speaker of the Arizona House of Representatives, and DES could consider including a wide range of stakeholders, such as representatives from AHCCCS, ADHS, and the Attorney General’s Office; public fiduciaries; representatives from local law enforcement; vulnerable adult advocates; Tribal representatives; legislative members; and members from the Arizona House of Representatives’ Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults.

In identifying participants for the working group, DES could also consider individuals who participated in developing the various plans mentioned previously, such as members of the Abuse & Neglect Prevention Task Force. This task force was created in 2019 in response to Executive Order 2019-03, but the focus of that task force, which included a wide range of state agencies, including AHCCCS, DES, and ADHS, and other stakeholders, was to make recommendations that would further protect and improve care for individuals with disabilities.⁴⁹ Although this task force did not develop a strategic direction for Arizona’s adult protective services system, several of its recommendations were aimed at improving the overall adult protective services system. As a result, including members from this task force and reviewing the reports related to this task force could help guide Arizona’s efforts to establish a strategic direction.

In addition, DES and the work group should establish a strategic direction for Arizona’s adult protective services system that ensures the safety of vulnerable adults and establishes protocols for services after an investigation by:

- Evaluating how Arizona’s adult protective services system can target systems beyond just the individual victim to help alleviate mistreatment risk.
- Determining whether a specific state agency should be assigned the responsibility of case management services to help ensure that vulnerable adults receive the services they have been referred to during and after a DES APS investigation and determining whether the services met the needs of vulnerable adults.
- Establishing processes, in conjunction with recommendations in Chapter Three, for measuring and reporting on vulnerable adult outcomes, including key outcomes that will help demonstrate whether Arizona’s processes are reducing maltreatment, vulnerable adult-centered, and providing services both during and after an investigation.
- Considering practices from other states, including those outlined in this report.
- Addressing system gaps outlined in this report.

⁴⁹ See: <https://www.azahcccs.gov/AHCCCS/Downloads/AbuseAndNeglectPreventionTaskForceReport2019.pdf>.

- Reviewing and considering whether to continue and or build upon efforts outlined in other plans, such as Report of the Abuse & Neglect Prevention Task Force (2019), Implementation and Impact of Arizona’s Abuse & Neglect Prevention Task Force Recommendations (May 2022), Arizona State Plan on Aging 2023-2026 (2023), Adult Protective Services Action Plan (March 2020), DES APS Year in Review Reports (SFYs 2020, 2021 and 2022), and DES Annual Report (SFY 2022).

Recommendations

1. **Establish a working group** – DES should work with the Governor, President of the Arizona Senate, and Speaker of the Arizona House of Representatives to establish and appoint members to a working group to develop a strategic direction for Arizona’s adult protective services system. Specifically, to ensure working group membership adequately represents various system stakeholders, the Governor, President of the Arizona Senate, Speaker of the Arizona House of Representatives, and DES should consider appointing 5 members each, for a total of 20 members, or appointing an alternate number of members with each appointing an equal number. When appointing working group members, the Governor’s Office, President of the Arizona Senate, Speaker of the Arizona House of Representatives, and DES could consider a wide range of stakeholders, such as representatives from AHCCCS, ADHS, and the Attorney General’s Office; public fiduciaries; representatives from local law enforcement; vulnerable adult advocates; Tribal representatives; legislative members; and members from the Arizona House of Representatives’ Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults.
2. **Develop report identifying roles/responsibilities and other needs** – DES in conjunction with the working group should develop a report that identifies the working group’s roles and responsibilities and identifies any authority, resources, legislation, or other action needed to ensure the working group’s ongoing success in identifying and implementing the strategic direction for Arizona’s adult protective services system. DES should submit the report to the Governor, President of the Arizona Senate, Speaker of the Arizona House of Representatives, Senate and House Health and Human Services committees, Joint Legislative Budget Committee, and Arizona House of Representatives’ Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults by November 1, 2024.
3. **Develop a strategic direction** – Once the roles and responsibilities and any needed authority, resources, legislation, or other action has been provided and/or approved, DES in conjunction with the working group should develop a strategic direction for Arizona’s adult protective services system that will help ensure the safety of vulnerable adults and establishes protocols for services during and after an investigation. This should include:

- Evaluating how Arizona’s adult protective services system can target systems beyond just the individual victim to help alleviate mistreatment risk;
 - Determining whether a specific state agency should be assigned the responsibility of case management services to help ensure that vulnerable adults receive the services they have been referred to after a DES APS investigation;
 - Establishing processes, in conjunction with recommendations in Chapter Three, for measuring and reporting on vulnerable adult level outcomes, including key outcomes that will help demonstrate whether Arizona’s processes are reducing maltreatment, vulnerable adult-centered, and provide services both during and after an investigation;
 - Considering practices from other states, including those outlined in this report;
 - Addressing gaps outlined in this report; and
 - Reviewing and considering whether to continue and or build upon efforts outlined in other plans, such as Report of the Abuse & Neglect Prevention Task Force (2019), Implementation and Impact of Arizona’s Abuse & Neglect Prevention Task Force Recommendations (May 2022), Arizona State Plan on Aging 2023-2026 (2023), Adult Protective Services Action Plan (March 2020), DES APS Year in Review Reports (SFYs 2020, 2021 and 2022), and DES Annual Report (SFY 2022).
4. **Develop action plan for implementing strategic direction**—Once the strategic direction is established, DES in conjunction with the working group should complete the following tasks: Develop an action plan for implementing Arizona’s strategic direction, including identifying DES and other state agency responsibilities, policies, protocols, practices, and/or statutory changes that are needed, and critical resources and commitments that must be in place for ensuring Arizona’s strategic direction can be met. The action plan should include specific tasks with estimated completion dates along with assigned responsibilities and a process to regularly review progress and modify the plan as needed.

CHAPTER THREE - ACCOUNTABILITY MECHANISMS

Legislative Request: Examine the current adult protective services system and consider best practices to improve the delivery of services, including creating accountability mechanisms including the capacity to produce accurate and relevant data on performance and outcome measures, use the data for performance management, processes for continuous quality review, mechanisms for qualitative review of system functioning, and outcomes for vulnerable adults.

Conclusion:

This review found that the DES APS data system is not set up to track and measure service outcomes for vulnerable adults. Neither ADHS nor AHCCCS reports on service outcomes associated with individual vulnerable adults. Service outcome information is critical to identifying ways to improve the delivery of services. In order for the Arizona adult protective services system to have the capacity to produce accurate data on performance and key vulnerable adult centered outcomes, DES in conjunction with the working group identified in Chapter Two, Recommendation #1, should identify accountability mechanisms, a set of common system wide outcomes and a system wide performance reporting process.

System Gaps Related to Accountability Mechanisms Exist

Although some state agency functions within Arizona’s adult protective services system have accountability mechanisms that include independent oversight, supervisory reviews, and external quality assurance processes, the adult protective services system as a whole lacks independent oversight and quality assurance processes. Specifically:

- **Federal oversight exists for ADHS and AHCCCS but not for DES APS** – ADHS has some independent oversight from CMS in areas that are related to vulnerable adults. For example, CMS conducts an annual formal assessment to determine whether ADHS is fulfilling its licensing responsibilities for federally certified long-term care facilities, such as whether it is timely initiating complaint investigations. Although these reviews are not focused on vulnerable adults, changes that ADHS makes to its processes may help improve safety and security of licensed facilities, which house some vulnerable adults.⁵⁰ Additionally, once every 3 years, CMS contractors and state Medicaid agencies, including AHCCCS, review sampled cases to help ensure that these state Medicaid agencies are meeting several requirements, such as making appropriate eligibility determination decisions to approve, deny, or disenroll an individual from healthcare coverage. Although these reviews are not focused on vulnerable adults, because some vulnerable adults are AHCCCS members, the reviews could help ensure some vulnerable adults are getting appropriately approved for AHCCCS coverage. However, DES APS does not have any federal oversight.⁵¹
- **DES APS, ADHS, and AHCCCS investigations processes include supervisory and/or secondary review** – As previously discussed in Chapter One, DES APS’ investigation process includes requirements for secondary reviews. Specifically, according to DES APS policy, cases proposed for substantiation must first be reviewed by an appeals specialist. Additionally, statute requires that once approved by DES APS, the Attorney General’s Office determines if there is sufficient evidence to support substantiation and placing the perpetrator to the DES APS registry, if not appealed. Additionally, DES APS policies and procedures require supervisory review before an investigation can be

⁵⁰ A September 2019 Auditor General performance audit of ADHS found the Department failed to investigate or timely investigate some long-term care facility complaints. The Auditor General’s 36-month follow-up report found that although the Department had begun to implement 6 of the 9 recommendations, substantial work remained to fully implement them and better protect the health, safety, and welfare of long-term care residents. See reports at: <https://www.azauditor.gov/reports-publications/state-agencies/health-services-department/report/arizona-department-health-6>.

⁵¹ Subsequent to our review, on September 12, 2023, the US DHHS, ACL issued a Proposed Rules Making notice. The proposed rule aims to improve consistency and quality of APS services across states and support the national network that delivers APS services, with the ultimate goal of better meeting the needs of adults who experience, or are at risk of, maltreatment. See: <https://www.federalregister.gov/documents/2023/09/12/2023-19516/adult-protective-services-functions-and-grant-programs>

closed, including a review of the vulnerable adult’s case plan, if applicable, to determine if it contains all required elements (see Chapter One, page 14, for more information about required case plan elements). Finally, AHCCCS and ADHS policies also outline supervisory review processes for the investigations that these agencies undertake which may involve vulnerable adults. For example, ADHS policy requires supervisory review before an investigation can be closed.⁵²

- **State independent oversight committees exist for some populations that include vulnerable adults but not for the adult protective services system or DES APS** – State statute has established several independent oversight committees, some of which provide oversight related to some populations that include vulnerable adults. For example, statute establishes three regional AHCCCS Independent Oversight Committees on Behavioral Health to help ensure that the rights of persons receiving behavioral health services through AHCCCS are protected, including but not limited to individuals with a serious mental illness. Statute also establishes five regional oversight committees for DES DDD that are responsible for providing support and review in matters relating to the rights of people with developmental disabilities, including but not limited to reviewing incidents of possible abuse and neglect, suicide attempts, and deaths. However, independent oversight committees have not been established to oversee the adult protective services system or DES APS.
- **AHCCCS contracts for external quality reviews in accordance with CMS requirements but ADHS and DES APS lack external quality review** – AHCCCS has contracted with an external quality review organization to annually validate whether each contracted health plan met national Medicaid benchmarks for established performance measures and to submit the results of its analysis to AHCCCS. Although these quality reviews are not specifically focused on vulnerable adults, they would review services provided to those vulnerable adults who are AHCCCS members. However, ADHS and DES APS do not receive external quality reviews.

⁵²Despite this supervisory review requirement, a May 2022 30-month follow-up report conducted by the Auditor General found that ADHS inappropriately closed most high-priority long-term care facility complaints without the required on-site investigation. The 36-month follow-up found that this practice stopped in July 2022. See reports at: <https://www.azauditor.gov/reports-publications/state-agencies/health-services-department/report/arizona-department-health-6>

Performance and Outcome Data Critical to Assessing System Effectiveness and Experts Recommend Measuring Several Outcome Areas for Adult Protective Services

The National Voluntary Consensus Guidelines for State Adult Protective Services Systems recommends state adult protective services systems collect, analyze, report and evaluate program performance so that information is available that: (1) describes how the program helps vulnerable adults, (2) helps workers and supervisors do their best work, and (3) can be used to tell a compelling story about the program and its effectiveness.⁵³

National Voluntary Consensus Guidelines for State Adult Protective Services Systems (March 2020)

The Voluntary Consensus Guidelines for State Adult Protective Services Systems are intended to promote an effective adult protective services response across the country so that all older adults and adults with disabilities, regardless of the state or jurisdiction in which they live, have similar protections and service delivery from adult protective services systems. The Guidelines also provide a core set of principles and common expectations to encourage consistency in the policies and practices of state adult protective service programs across the country.

In addition as discussed in Chapter Two, experts in the elder mistreatment arena are recommending that the outcome areas for adult protective services to monitor are: (1) reduced elder and vulnerable adult mistreatment (i.e., harm reduction) and recurrence of victimization; (2) implementation of service or case plans that are tailored to each victim's goals and needs (i.e., vulnerable adult centered); and (3) adult protective system policies and practices that result in vulnerable adults engaging in services during and after an investigation that alleviate mistreatment. Providing case management services for vulnerable adults during and after an investigation to ensure the vulnerable adults receive the services they need and determine that the services had the desired outcome can help ensure these outcomes are measured.

Some Program Data Collected and Publicly Available but Key Outcome Measures/Data for Vulnerable Adults Lacking

For AHCCCS and ADHS, neither agency reports on outcomes associated with individual vulnerable adults. For AHCCCS, the focus on safety and quality issues is at the level of monitoring managed care plans and providers. For ADHS the focus is at the facility level for licensing violations. While a vulnerable adult served by DES APS may be receiving services

⁵³ National Voluntary Consensus Guidelines for State Adult Protective Systems (March 2020). Administration for Community Living, Office of Elder Justice and Adult Protective Services, US DHHS, Washington, DC.

paid for by AHCCCS and or in an ADHS licensed facility, neither agency reports on vulnerable adult outcomes at the case level for this population.

DES APS is the only agency that is reporting information related specifically to vulnerable adults. DES APS has a public facing data dashboard launched in 2021 that tracks data on allegations, caseload, alleged perpetrators, demographics, communications, and reporting sources.⁵⁴ For example, on this dashboard one can view information on the number of reported allegations by month and by type of report, e.g., Emotional Abuse Report, Sexual Abuse / Assault, Self- Neglect and four other types. DES APS also fully participates in the National Adult Maltreatment Reporting System. This national reporting system collects quantitative and qualitative data on state adult protective services practices and policies, and the outcomes of investigations into the maltreatment of older adults and adults with disabilities.

However, no information is being captured by DES APS or the other state agencies relative to the vulnerable adult-centered outcome areas that experts indicate the system should be moving towards. Specifically:

- The Arizona adult protective services system lacks data on reducing mistreatment and reducing re-victimization. DES APS is reporting to NAMRS when DES APS has information that the vulnerable adult was the subject of a previous report of victimization and /or self-neglect. However, DES APS does not track alleviation of mistreatment during and after an initial or subsequent investigation for vulnerable adults . The Arizona adult protective services system lacks data on the extent to which vulnerable adult services or case plans are centered on the vulnerable adult’s needs and goals. DES APS investigators capture case service planning activities in a “comments section of the Plans tab, when a vulnerable adult case plan can be completed,” in the myAPS administrative data system. Documentation is maintained in a comments section and this type of text-based data is not useful for tracking performance on an indicator over time.
- The Arizona adult protective services system lacks data on whether or not DES APS vulnerable adults are engaging with services during an investigation that alleviate mistreatment. No information is collected about services after an investigation is closed.⁵⁵

⁵⁴ See: <https://des.az.gov/APSDData>

⁵⁵ APS Investigations Policy and Procedure Manual, Chapter 18, September 2022.

Several Reasons for Lack of Vulnerable Adult Outcome Data

We identified several reasons why Arizona is lacking key outcome data.

Limitations with DES APS Data – DES APS data system is not set up to track and measure service outcomes. Specifically, when a vulnerable adult is referred to services the DES APS data system lacks data fields that would indicate whether the vulnerable adult received services, what types of services they received and when they received those services from what provider. Instead, the DES APS data system includes a field for tracking the status of a referral to service. Examples of most common statuses in DES APS data include service not required, vulnerable adult accepted service, vulnerable adult refused service, and risk ceased. DES APS data includes these statuses only for vulnerable adults who were referred for services.

No Unique Identifier is Used – DES APS does not use a unique identifier for vulnerable adults it refers to other agencies for services, such as the regional Area Agencies on Aging (AAAs) and DES DDD. Without this unique identifier it is hard to identify whether a referred vulnerable adult received services or not. For example, as part of this audit, we attempted to match DES APS vulnerable adult level data with DES vulnerable adult level data received by DES from AAAs for billing purposes.⁵⁶ Specifically, using data fields such as vulnerable adult first and last name, date of birth, zip code, we tried to match vulnerable adults to services received, but were unable to merge the data files without unique identifiers.

Other entities do not report service outcome data to DES APS – DES APS does not receive information on use of or provision of services from entities within the Arizona adult protective services system who may be providing services. For example, AAAs do not provide data to DES APS on the services they have provided to vulnerable adults DES APS has referred to them for services.

Concerns with Confidentiality - All three agencies indicated concerns about sharing vulnerable adult data that may allow for an individual to be identified. For example, A.R.S. §46-460 stipulates that all information gathered, created by, or contained in DES APS records is confidential, but provides some specific instances where DES can share information with units of government for official purposes. In addition, AHCCCS reported that confidentiality laws such as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prevents it from sharing and reporting on vulnerable adult information. However, there are allowances

⁵⁶ It is important to note that this type of billing for services information may only show vulnerable adults who actually received services, it may not show vulnerable adults who are still waiting for services, those who have declined services, or those vulnerable adults who dropped off the waiting list for other reasons, such as passing away. Finally, AAAs are only one of several organizations DES APS refers vulnerable adults to, so even if AAAs had data on service receipt and outcomes for AAA vulnerable adults that could be matched to DES APS vulnerable adult data, this would only be a portion of vulnerable adults referred for services.

under HIPPA for data sharing, such as regarding victims of abuse, neglect, or domestic violence. In certain circumstances, covered entities may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence⁵⁷. Also, confidentiality laws would generally not preclude agencies from tracking vulnerable adult outcomes at an aggregate level similar to the aggregate data presented through the DES APS Data Dashboard.

Lack of case management processes— As previously discussed in Chapter Two (pages 22 to 33), the Arizona adult protective services system lacks case management processes for all vulnerable adults, which may contribute to the lack of outcome data. Specifically, no State agency has been assigned the responsibility for providing case management for all vulnerable adult cases that DES APS has referred to services during and after an investigation to ensure vulnerable adults receive the services they need and determine that the services had the desired outcome.

DES Best Positioned to Lead on Developing Outcome Measures and Performance Reporting Process

Similar to what was discussed in Chapter One, DES is also well positioned to lead the effort to develop outcome indicators and measures for Arizona’s adult protection services system. For example, DES APS has reported that during fiscal year 2024, it is participating in a national workgroup to develop national standards and consistent data collection associated with the National Adult Maltreatment Reporting System (NAMRS).

As it develops a strategic direction for Arizona’s adult protective services system, DES, in conjunction with working group identified in Chapter Two, Recommendation #1, should identify accountability mechanisms that should be implemented for Arizona’s adult protective services system, such as independent oversight, and quality assurance processes. The working group should also identify and develop a set of common, system-wide outcomes that can be used to assess the effectiveness of Arizona’s strategic direction, including identifying which entities will collect outcome data and how they will do so, and developing quality assurance process for ensuring the outcome data is complete and accurate. The outcomes should include (1) reduced elder and vulnerable adult mistreatment; (2) reduced recurrence of victimization and or self-neglect; (3) service plans that are vulnerable adult-centered; and (4) vulnerable adult engagement with services during and after an investigation that alleviate mistreatment. Consistent with the National Voluntary Consensus Guidelines for State Adult Protective Services Systems, the working group should identify a system wide performance reporting process that compiles performance and outcome information on an annual basis to assesses the

⁵⁷ 45 C.F.R. § 164.512(a), (c). See: <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164>

effectiveness of Arizona’s strategic direction.⁵⁸ In designing the performance reporting process, the working group should resolve the data issues identified in this report, including, limitations of a lack of data on service provision; lack of unique identifiers; absence of outcome reporting between agencies, concerns with confidentiality and lack of case management processes that may be a barrier to sharing vulnerable adult level information and reporting on aggregate outcomes for vulnerable adults. In addition, given the scope of this effort, it would be important for the working group to develop a plan outlining the authority, roles and responsibilities, and resources needed to design and implement the system-wide reporting process.

Recommendations

1. **Identify accountability mechanisms** – DES in conjunction with the working group identified in Chapter Two, Recommendation #1, should identify accountability mechanisms that could be implemented for Arizona’s adult protective services system, such as independent oversight and quality assurance processes.
2. **Identify and develop common, system-wide outcomes** – DES in conjunction with the working group identified in Chapter Two, Recommendation #1, should identify and develop a set of common, system-wide outcomes that can be used to assess the effectiveness of Arizona’s strategic direction, including identifying which entities will collect outcome data and how they will do so, and developing a quality assurance process for ensuring the outcome data is complete and accurate. The outcomes should include (1) reduced elder and vulnerable adult mistreatment; (2) reduced recurrence of victimization and or self-neglect; (3) service plans that are vulnerable adult-centered; and (4) vulnerable adult engagement with services during and after an investigation that alleviate mistreatment.
3. **Identify system-wide performance reporting process and develop report identifying roles/responsibilities and other needs** – DES in conjunction with the working group identified in Chapter Two, Recommendation #1, should identify a system-wide performance reporting process that could compile performance and outcome information on an annual basis to assess the effectiveness of Arizona’s strategic direction. In designing the performance reporting process, the working group should resolve the data issues identified in this report, including, limitations of a lack of data on service provision; lack of unique identifiers, absence of outcome reporting between agencies, concerns with confidentiality; and lack of case management processes that may be a barrier to sharing vulnerable adult level information and reporting on

⁵⁸ National Voluntary Consensus Guidelines for State Adult Protective Systems (March 2020). Administration for Community Living, Office of Elder Justice and Adult Protective Services, US DHHS, Washington, DC.

aggregate outcomes for vulnerable adults. DES in conjunction with the working group should develop a report that identifies the authority, roles and responsibilities, and resources needed to design and implement the system-wide reporting process. DES should submit the report to the Governor, President of the Arizona Senate, Speaker of the Arizona House of Representatives, Senate and House Health and Human Services committees, Joint Legislative Budget Committee, and Arizona House of Representatives' Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults.

4. **Implement system-wide performance reporting process** – Once the roles and responsibilities and any needed authority, resources, legislation, or other action has been provided and/or approved, DES in conjunction with the working group should take the necessary steps to implement a system wide performance reporting process that compiles performance and outcome information on an annual basis to assess the effectiveness of Arizona's strategic direction.

CHAPTER FOUR - COMMUNITY ENGAGEMENT

Legislative Request: Examine the current adult protective services system and consider best practices to improve the delivery of service in this state, including strategies for community engagement, including engaging with families, vulnerable adults, and service providers.

Conclusions:

National guidelines related to community engagement in adult protective services systems indicate adult protective services programs should devote resources to educating the public on defining abuse, reporting abuse, and the program's authority. Our review of DES APS' community engagement efforts found DES APS has a variety of community engagement practices aligned with national guidance and similar to practices in 3 other states we reviewed, including:

- availability of information on its website.
- community member training on recognizing and reporting maltreatment.
- partnering with AHCCCS, ADHS, and the Governor's office in June 2023 to launch Speak Up AZ!, a public awareness campaign to educate the public and mandated reporters to recognize and report signs of abuse, neglect, and exploitation of adults.

DES APS has additional opportunities to engage vulnerable adults, their families, and advocates on development of a strategic direction for Arizona's adult protective services system.

Community Engagement Promising Practices

National guidelines developed to promote an effective adult protective services response include guidance on community engagement. Specifically, the Administration for Community Living (ACL) 2020 Voluntary Consensus Guidelines for State Adult Protective Services Systems⁵⁹ recommends state adult protective services programs devote resources for engaging their communities through public awareness and/or educational sessions. The Guide also mentions recent research indicates a lack of awareness and miscommunication may indicate a need for educational interventions to help reduce repeat contacts with the adult protective services system that are not appropriate. These sessions should minimally include:

- Defining adult maltreatment.
- Guidance on how and when to report.
- Discuss state APS authority and limitations.

In addition, we identified examples of state adult protective services community engagement from three other states.⁶⁰ Community engagement activities in these states included stakeholder presentations; interdisciplinary trainings with law enforcement, state adult protective services workers, state prosecutors, medical professionals, and other community professionals; attending and tabling at community events; creating and disseminating informational flyers; and displaying information on billboards. While national guidelines are provided for state adult protective services agencies, such as DES APS, there are no specific standards set for other agencies that are part of the adult protective services system, such as ADHS or AHCCCS.

DES APS Community Engagement Activities Align with National Guidance and Similar to other State Activities

DES APS uses both public awareness and educational sessions to engage the community. In line with national best practice guidance, these community engagement activities provide a definition of maltreatment, guidance on how and when to report abuse of vulnerable adults, and information on DES APS' authority and limitations. AHCCCS and ADHS also have participated in some outreach activities.

⁵⁹ National Voluntary Consensus Guidelines for State Adult Protective Services Systems, 1M. Community Outreach and Engagement; see: <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>

⁶⁰ Other state examples come from Nevada, Massachusetts, and New York and were based on direct asks from the national consultants' contacts.

Public awareness information available through the DES APS website⁶¹, posted at facilities, and communicated through public media campaign. The DES APS website includes information on DES APS' role and authority in investigating reports of adult maltreatment, definitions of adult maltreatment, guidance on how and when to report cases of maltreatment, the authority and limitations of DES APS, and a free, 60-minute online training, "Recognizing and Reporting Maltreatment Training."⁶²

Licensed facilities are required to inform residents and visitors about how to report vulnerable adult abuse through signage at facilities. Specifically, Arizona Administrative Code establishes the various information that must be posted, including how to contact and report concerns to DES APS and others, such as ADHS and the DES Long-term Care Ombudsman Program, depending on the facility type.^{63, 64}

In addition, on June 26, 2023, in partnership with AHCCCS, ADHS, and the Governor's office, DES APS announced an extensive, multi-million-dollar public awareness campaign. Speak Up AZ!, funded by the federal American Rescue Plan, is intended to use various media channels including radio, television, billboards, and Internet to educate the public and mandated reporters about recognizing and reporting signs of abuse, neglect, and exploitation of adults. As of July 2023, the campaign website (in English and Spanish) includes information on who is at risk, types of abuse, warning signs, how and whom to report, and other resources, such as ways to volunteer.⁶⁵ The website links to DES APS' online system for reporting abuse, neglect, and exploitation of adults and has the DES APS hotline phone numbers. In mid-July 2023, Speak Up AZ! social media accounts included Facebook, LinkedIn, and YouTube.

DES APS Educational Sessions – According to our review of information contained in DES APS outreach logs, between June 13, 2022, and June 15, 2023, DES APS conducted 20 presentations to a total of over 500 community members, stakeholders, and mandated reporters, such as teachers and law enforcement personnel. Specifically, DES APS has developed two presentations for stakeholders. The first educates mandated reporters on their duty to report, how to recognize signs of abuse and neglect, and how to report. The second informs the community about DES APS, their authority, and role in the greater system of supports. For example, the DES APS Outreach Team presented an educational session to the Northern

⁶¹ See: <https://des.az.gov/services/basic-needs/adult-protective-services>.

⁶² See: <https://des.az.gov/services/basic-needs/adult-protective-services-aps/training-education-and-outreach>.

⁶³ Title 9, Chapter 10 of the Arizona Administrative Code. https://apps.azsos.gov/public_services/Title_09/9-10.pdf.

⁶⁴ A.A.C. R9-10-403(G)(3)(b)-(c) directs Nursing Care Institutions administrations to ensure the name, address, and telephone number of the following are conspicuously posted: (i) the ADHS' Office of Long-Term Care, (ii) the State Long-Term Care Ombudsman Program, (iii) DES' APS; and also requires a notice that a resident may file a complaint with ADHS concerning the nursing care institution. A.A.C. R9-10-803(D)(3) directs Assisted Living Facilities' management to ensure that the current phone numbers for the following are conspicuously posted: (a) the unit in ADHS responsible for licensing and monitoring, (b) DES APS, (c) the state Long-term Care Ombudsman Program, (d) and Arizona Center for Disability Law.

⁶⁵ See campaign website: <https://speakupaz.org/be-proactive/volunteer-to-support-victims/>

Arizona Witness Advocacy group on January 18, 2023 and Prescott and Cottonwood Law Enforcement and regional first responders on January 26, 2023. In addition, DES first hosted a World Elder Abuse Awareness Day conference in 2018 (see textbox below for more information). More than 250 people attended the June 15, 2023 Arizona conference. Topics covered a variety of areas including intimate partner violence and neurocognitive disorders, caregiver supports, the impact of historical trauma on elder abuse, and seniors facing homelessness. Exhibitors at the conference included AARP, health organizations, community coalitions, the U.S. Dept. of Veterans Affairs, the Social Security Administration, and the conference included presentations by the Arizona Attorney General's Office, including Kris Mayes.

World Elder Abuse Awareness Day (WEAAD) is a global initiative launched by the International Network for the Prevention of Elder Abuse and the World Health Organization, in partnership with the United Nations. It serves as an opportunity for communities worldwide to increase understanding and awareness of elder abuse, neglect, and exploitation. WEAAD aims to shed light on the cultural, social, economic, and demographic factors contributing to this crisis. It brings together residents, professional organizations, and communities through conferences, providing a platform for networking, sharing information, and advocating for the protection of aging adults and individuals with disabilities aged 18 and above.

Source(s): United Nations - World Elder Abuse Awareness Day Background; DES World Elder Abuse Awareness Day Conference.

DES APS has Opportunities to Continue or Enhance Community Engagement Activities Directly Involving Vulnerable Adults and their Families

DES APS has participated in and started using activities to obtain input from vulnerable adults or their families. DES APS should seek additional opportunities to engage vulnerable adults, their families, and advocates as it works to develop a strategic direction for Arizona's APS system, as recommended in Chapter One. Specifically:

DES APS 2022-2023 pilot vulnerable adult satisfaction survey - Acknowledged as a promising practice by the national consultants participating in the audit, DES APS started piloting a vulnerable adult satisfaction survey in August 2022. DES APS quality assurance staff collect responses through monthly phone calls to obtain feedback on vulnerable adults' interactions with DES APS and their level of satisfaction with APS services. Respondents rate interactions and communication, how DES APS helped the vulnerable adult meet their needs, and how DES

APS can improve communication and quality of service. Results of the survey are compiled into major themes, reported monthly by the DES APS QA team, and shared with APS program leadership and the Division of Adults and Aging Services executive leadership to assess opportunities for system-wide improvements. In addition, major survey themes are shared twice yearly with all DES APS supervisors at mandatory meetings. DES APS indicated one example of a specific change resulting from the survey was the creation of a centralized team to aid investigators in finding local resources for vulnerable adults. DES APS plans to continue conducting monthly surveys and expand the survey audience to include other participants involved in DES APS cases, such as reporting sources. As of July 2023, DES APS is conducting the survey in Spanish. DES APS should consider incorporating survey responses into performance reports.

DES APS Last Hosted a Stakeholder Meeting in January 2020 with ADHS – DES APS and ADHS held a joint stakeholder meeting in January 2020 intended to engage vulnerable individuals, their families, and supporting organizations to review process improvements, develop strategies, and propose actions to inform the DES APS Action Plan.⁶⁶ However, neither agency has held a similar stakeholder meeting since. Based on our review of DES APS outreach logs, it does not appear DES APS is formally or consistently engaging with vulnerable adults and their families to collect feedback, such as through stakeholder meetings. As it works on developing a strategic direction with stakeholders (see Chapter Two), however, DES has an opportunity to reengage with vulnerable adults and their families. Obtaining input from these stakeholders during the strategic development process will help ensure the strategic direction addresses relevant needs and gaps identified by these stakeholders.

Recommendations

1. **Incorporate community engagement into strategic direction** – DES in conjunction with the working group identified in Chapter Two, Recommendation #1, should incorporate community engagement into the strategic direction for Arizona’s adult protective services system identified in Chapter Two, Recommendation #3.
2. **Continue community engagement efforts** – DES APS should continue community engagement efforts and ensure educational materials at a minimum include the information recommended by the ACL 2020 Voluntary Consensus Guidelines for state APS systems.

⁶⁶ ADHS and DES developed a stakeholder-driven action plan in March 2020, with 4 main goals, to improve the adult protective services system in Arizona as directed by the House of Representatives Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults. <https://des.az.gov/services/basic-needs/adult-protective-services/systematic-improvements>

3. **Continue satisfaction survey** – DES APS should continue its vulnerable adult satisfaction survey; expand it to include other case participants; offer a Spanish language option; continue to use feedback from the survey to improve its processes for vulnerable adults; and consider incorporating survey responses into performance reports.
4. **Continue to partner with key agencies** – DES APS, AHCCCS, and ADHS should continue to find ways to partner in community engagement activities, such as Speak Up AZ!, to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults.
5. **Obtain input from vulnerable adults** – DES in conjunction with the working group identified in Chapter Two, Recommendation #1, should involve vulnerable adults and their families in the development of the strategic direction for Arizona’s adult protective services system.

CHAPTER FIVE - AREAS FOR FUTURE REVIEW

Legislative Request: Examine the current adult protective services system and consider best practices to improve the delivery of services in this state, including determining the need for and frequency of regular, periodic performance evaluations and the recommended areas for future reviews of adult protective services by an independent outside evaluator.

We identified four areas for further review of the adult protective services system.

Investigation Process

Timeliness

During fiscal years 2020 to 2022, DES APS opened 73,083 investigations (see Exhibit 2, page 8 for more information). DES APS has a performance goal of completing investigations within 60 days. However, over the past 3 State fiscal years, DES APS' average length of time to complete an investigation was longer than 60 days. Furthermore, the length of time DES APS takes to complete an investigation has increased substantially from an average of approximately 81 days in State fiscal year 2020 to an average of 101 days in State fiscal year 2022. Additionally, DES APS' average time to complete an investigation was well above the national average of 55 days in 2020 and 51 days in 2021.⁶⁷ The percentage of investigations completed within 60 days was 29 percent in fiscal year 2020, 26 percent in fiscal year 2021, and 20 percent in fiscal year 2022. However, DES APS reported in the State fiscal year 2023 it has increased the percentage of investigations completed within 60 days to over 47 percent as of June 2023.

Although 54% of DES APS staff who responded to the survey in February 2023 reported that they *Strongly Agreed / Agreed* that APS was timely in helping vulnerable adults achieve greater safety and security, DES APS is not meeting its investigation timeliness goal.

⁶⁷ Adult Maltreatment Report: 2020 and Adult Maltreatment Report: 2021 - National Adult Maltreatment Reporting System, see: <https://namrs.acl.gov/>

DES APS reported it is aware that on average it is taking longer than its 60-day goal to complete an investigation and is taking steps to try to reduce the time. For example:

- In September 2022, DES APS launched a new investigator training and onboarding program. DES APS investigators receive eight (8) weeks of in-depth, comprehensive instruction, observation, shadowing, and mentoring in preparation to manage their caseload quicker and with a greater understanding.

In October 2022, DES APS created the Aged Case Unit to take over cases when an investigator leaves DES APS. Previously, these cases were reassigned to staff who already had a caseload, which DES APS reported resulted in delays. From October 2022 to June 2023, the Aged Case Unit closed 1,324 cases.

- In April 2022, DES APS created a dashboard of all aged cases with the date of the last activity on the case. Managers use dashboard information to check with staff on individual cases.

Although DES APS reports a higher percentage of investigations are being completed within 60 days,⁶⁸ an evaluation of the effectiveness of the actions that DES is implementing to improve investigation timeliness and identification of any root causes driving various lengths of time at each step of the investigative process is warranted.

Substantiation Rates

In Arizona, the overall proportion of reports investigated that resulted in a substantiated finding was less than 1 percent over the past 3 State fiscal years (see Exhibit 2 on page 8). This rate is well below the proportion of substantiated findings in other states.

Substantiated decisions indicate the APS investigation found supporting evidence that the alleged allegations of abuse, neglect, or maltreatment occurred and result in the perpetrator being placed on the Arizona APS Registry. [A.R.S. 46-459]

Specifically, the National Adult

Maltreatment Reports (which include Arizona findings in the calculations) found 33 percent of reports with substantiated findings in 2020 and 29 percent in 2021, significantly larger proportions than in Arizona.

Elder abuse experts are clear that substantiating cases is important for victims to feel they have received justice, based on the experiences and related research projects our national consultants have been involved with. Specifically:

⁶⁸ DES APS reported that in the state fiscal year 2023, the percentage of investigations completed in 60 days or less increased from 35% in July 2022 to over 47% as of June 2023.

- People who have suffered victimization at the hands of an offender/perpetrator often derive a sense of justice from having their abuse/neglect allegations substantiated, much like crime victims seeking justice from the criminal justice system. Having an official body such as DES APS or the criminal courts declare an allegation substantiated can be profoundly important psycho-socially to victims and help them to heal and recover from the harm sustained. Conversely, not substantiating allegations often leaves victims feeling justice has not been served and re-traumatized by the official system intended to protect victims.
- Financial support and compensation from the US Department of Justice Office for Victims of Crime can often be obtained for victims served by state adult protective services programs when there is a substantiated abuse or neglect report. State adult protective services programs can assist victims whom they serve in applying for these funds to cover important expenses incurred by victims, including medical and equipment expenses.⁶⁹ To receive these funds, a victim must either file a police report regarding their victimization or have a substantiated state adult protective services report to document the victimization.
- Substantiating cases can lead to the perpetrator being placed on a registry, potentially deterring and preventing future abuse to that or other vulnerable adults. According to a National Adult Protective Services Association review of state registries, (NAPSA, 2018), most registry processes begin with a state APS investigative decision.⁷⁰ A.R.S §46-459 dictates the DES APS Registry include perpetrator name, date of birth, and type of maltreatment.

NAPSA reports that states with an adult protective services registry have the lowest substantiation rates nationally due to various factors including the time it takes for an external entity to review the evidence and make a determination. In addition, according to NAPSA, of 19 states that maintain an adult protective services registry, Arizona is 1 of 5 states that has two levels of substantiation, substantiated and verified, associated with different levels of evidentiary thresholds for investigation findings.⁷¹ Specifically, in Arizona:

- **Substantiation** means that there is a preponderance of evidence to support that abuse, neglect, or exploitation of a vulnerable adult has occurred. Substantiation decisions include a review of the DES APS' proposed substantiation by the Attorney General, notification of and right to appeal for the alleged perpetrator, and a final decision by the DES Director. Only substantiated findings result in a perpetrator being placed on the perpetrator registry.

⁶⁹ See: <https://ovc.ojp.gov/about/crime-victims-fund> for information.

⁷⁰ See: <https://www.napsa-now.org/wp-content/uploads/2018/05/APS-Abuse-Registry-Report.pdf>

⁷¹ See: <https://www.napsa-now.org/wp-content/uploads/2018/05/APS-Abuse-Registry-Report.pdf>

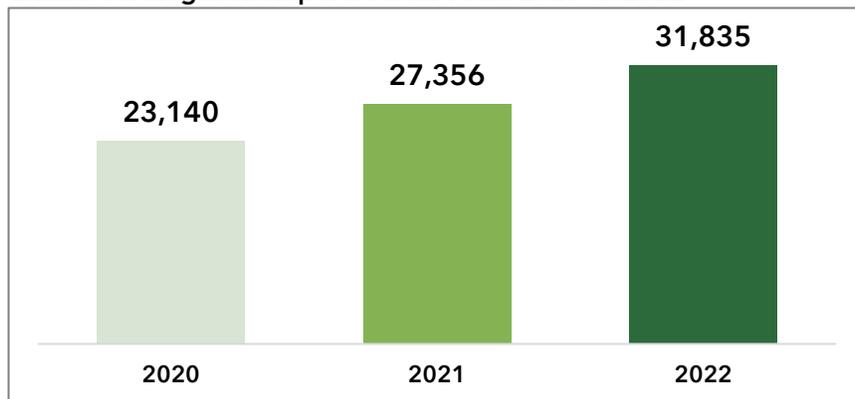
- **Verified** means there is preponderance of evidence to support that the adult is vulnerable and the allegation(s) occurred but APS will not propose-to-substantiate due to one or more of the following reasons: the allegation is self-neglect; the case involves lottery scams or telemarketers; the case involves a vulnerable adult caring for another vulnerable adult; or the case involves an unknown perpetrator or deceased perpetrator.

Investigation Quality

External stakeholders cited potential problems with investigation quality. In addition, some DES APS staff who responded to the survey cited concerns with investigation quality due to the size of their case load. Stakeholders from community-based agencies and colleagues at other state agencies commented that DES APS staffing levels are limiting the efficiency and effectiveness of the agency to carry out its mission. Similarly, in its Fiscal Year 2024 Budget Request, DES communicated concerns with increases in allegation reports (see Exhibit 8 below for increase in allegation reports between fiscal year 2020 through 2022; and see Exhibit 2, page 8 for total information on report, investigation and dispositions).⁷² According to DES APS' data dashboard, caseworkers had an average of 58 cases in fiscal year 2022, despite DES' goal to reach 25 cases per caseworker, the nationally recommended standard caseload ratio. In fiscal year 2022 the number of DES APS field investigators increased from 161 to 183 in total.⁷³

From the DES APS staff survey conducted in February 2023: 45% of DES APS staff who responded to the survey in non-supervisory roles disagreed or strongly disagreed with the statement "The size of my workload enables me to be effective."

Exhibit 8. Allegation Reports Fiscal Years 2020 to 2022



Source: LMA staff analysis of DES APS Data Dashboard information for fiscal years 2020 through 2022.

An independent evaluation of DES APS' investigation process could help determine the causes for lengthy investigations and lower substantiation rates and examine the quality of DES APS' investigations.

⁷² See: <https://des.az.gov/about-des/budget-information>.

⁷³ DES Division of Aging and Adult Services, Adult Protective Services. State Fiscal Year in Review: July 1, 2021 to June 30, 2022.

Guardianship Provided by County Public Fiduciaries

Stakeholder interviews indicated obtaining fiduciary services for vulnerable adults needing guardianship can be challenging. As mentioned in Chapter One, DES APS may refer a vulnerable adult to a public fiduciary for services, such as for guardianship if a person is incapacitated, a conservator for persons whose assets need protection, or a personal representative for the administration of a decedent's estate. DES APS does not have the authority to perform fiduciary duties, such as emergency guardianship, and must petition the court for guardianship or other protective orders.⁷⁴ According to DES APS, the public fiduciary provision is a barrier to connecting vulnerable adults with services, potentially attributed to:

- Public fiduciaries will not intervene without a court order.
- Filing a petition for guardianship requires multiple documents that take time to collect: a medical report stating the vulnerable adult cannot make informed decisions, a waiver of appointment from each family member, and the vulnerable adult's financial information.⁷⁵
- The fiduciary investigation to determine if guardianship is appropriate can take up to 3 months for a decision.

DES APS data showed 469 vulnerable adults were referred for guardianship or fiduciary services between July 2021 and April 2023. However, the status of public fiduciary appointment and timeliness of responses cannot be extrapolated from the DES APS data tracking system without additional extensive review.

While the scope of this review did not assess the court system and specifically public fiduciary responsiveness, the function of public fiduciaries in providing guardianship to vulnerable adults involved in DES APS investigations is important. As such, we recommend a future review examine barriers to obtaining guardianship and the role of public fiduciaries in providing services to vulnerable adults.

⁷⁴ Arizona Revised Statutes [A.R.S.] § 46-452.

⁷⁵ Arizona Revised Statutes [A.R.S.] § 14-5303.

AAA Service Capacity

As discussed in Chapter One, AAAs provide services to older adults, including vulnerable adults referred by DES APS. According to stakeholder input, potential barriers to vulnerable adults receiving services from AAAs include services being available to all older adults, service provider staffing capacity, case prioritization, and availability of services in rural areas. Specifically:

- AAAs serve all older adults, not just vulnerable adults DES APS refers.⁷⁶
- According to AAA director interviews and other stakeholder input, staff capacity limits service delivery to referred individuals and availability of services in the community.
- DES APS refers adults to the AAAs, the priority AAAs assign may not align with the need identified by the DES APS investigation, which may result in vulnerable adults waiting longer for needed services. According to AAA directors, priority is based on such criteria as:
 - Activities of daily living score⁷⁷
 - Number of recent hospital stays
 - Number of emergency room visits
 - Referral by DES APS
- Although the Older Americans Act emphasizes the need for providing services to older adults living in rural settings, various stakeholders including AAA directors and DES APS staff and leadership indicated an overall lack of services available in rural areas.

Additional review to identify causes of barriers or delays in service delivery to vulnerable adults by AAAs and their service providers is recommended.

⁷⁶ Older Americans Act of 1965 as Amended by Public Law 116-131, March 25, 2020.

⁷⁷ The Activities of Daily Living (ADL) scale measures the level of independence an individual demonstrates when completing basic tasks of everyday life including eating, dressing, and bathing. Katz, Sidney. 1983. Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living. *Journal of the American Geriatrics Association* 31:721-727.

MOUs with Tribal Nations

Arizona has the third largest American Indian population among all 50 U.S. states. The state's rural population is 15 percent American Indian, and more than half of Arizona's 15 counties include reservation lands within their borders. Of the 22 federally recognized Tribes in Arizona, there are only three federally recognized Tribes with which DES has current memorandums of understanding:

- Colorado River Indian Tribe
- Fort Mojave Indian Tribe
- Salt River Pima-Maricopa Indian Community

While these Tribes have sovereignty, the MOUs apply to individuals who are *non-tribal members* living on tribal lands for whom APS might be referred or receive a report. In what ways a non-Tribal member may be involved in a case of abuse/neglect is unknown -- they could be a perpetrator, a family member, and/or a victim. The purpose of the MOUs is to provide permission to DES APS to investigate reports of maltreatment of non-Native American vulnerable adults residing on or occurring on tribal/reservation lands. In addition, the MOUs outline a process for Tribal social services to report concerns regarding non-tribal members to DES APS and similarly for the DES APS to report concerns of a Native American vulnerable adult to the appropriate Tribal social services system.⁷⁸

Having MOUs to promote collaboration with other entities during investigations and implement services to benefit vulnerable adults is consistent with national guidelines.⁷⁹ We attempted to interview Tribal representatives to collect feedback on how these MOUs are functioning but were unable to complete any interviews. It is recommended that an independent evaluation be designed with these three Tribal authorities to identify what is working and what can be improved with the current MOUs. In addition, the evaluation could assess the need for adopting MOUs with Tribes that currently do not have them, including identifying what, if any, specific barriers may exist for other Tribes to enter into agreements with DES APS.⁸⁰

⁷⁸ Review of Memorandum of Understandings between DES APS and the 3 tribal nations: Colorado River Indian Tribe; Fort Mojave Indian Tribe; Salt River Pima-Maricopa Indian Community.

⁷⁹ National Voluntary Consensus Guidelines for State Adult Protective Services Systems, 2020. See: <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>.

⁸⁰ In the DES Arizona State Plan on Aging for 2023 to 2026 there is an objective area focused on closing current gaps in aging services infrastructure and delivery systems (pp. 27-28), especially to underserved areas and Native American communities are noted in this strategy area.

APPENDIX A - ABUSE & PREVENTION TASK FORCE

In 2019, Arizona established the abuse and neglect prevention task force. According to the *Implementation and Impact of Arizona's Abuse & Neglect Prevention Task Force Recommendations* report, completed in May 2022 "Following a high profile incident of sexual abuse at a Hacienda Healthcare facility in Arizona in 2018, the State of Arizona took measures to prevent abuse and inform abuse monitoring, including an Executive Order (2019-03) issued by [former] Governor Ducey which established an Abuse & Neglect Prevention Task Force to ensure the safety of persons with intellectual and developmental disabilities in Arizona. The Task Force generated 30 Recommendations that included actions across 12 domains directed at the betterment of abuse prevention across Arizona's social service system including Arizona Health Care Cost Containment System (AHCCCS), Arizona Department of Economic Security (DES), and Arizona Department of Health Services (ADHS)." This report includes results of surveys the Task Force conducted of service providers, health care plan members and their families. Overall, the report concludes that the recommendations had been implemented as written, and the Task Force efforts produced positive results related to the protection of vulnerable Arizonans.

For more information on this task force, we have included the following links:

- 2019 Report *Report on Abuse & Neglect Prevention Task Force*:
<https://www.azahcccs.gov/AHCCCS/Downloads/AbuseAndNeglectPreventionTaskForceReport2019.pdf>
- 2022 Report *Implementation and Impact of Arizona's Abuse & Neglect Prevention Task Force Recommendations*:
https://www.azahcccs.gov/AHCCCS/Downloads/AbuseAndNeglectPrevention_TF_Recommendations-SonoranUCEDD.pdf
- Abuse & Neglect Prevention Task Force website:
<https://www.azahcccs.gov/AHCCCS/CommitteesAndWorkgroups/abuseneglect.html>

APPENDIX B - METHODOLOGY

LeCroy & Milligan Associates, Inc. on behalf of the Arizona Auditor General conducted this independent review of the adult protective services system and consideration of best practices to improve the delivery of services to vulnerable adults in Arizona. The audit was conducted as outlined in Laws 2022, Ch. 313, §55.

Various methods were utilized to examine the issues addressed in this audit and recommendations for the strategic direction of the adult protective services system. Before any data gathering or fieldwork, LMA contracted with two national consultant experts in the adult protective services field to advise on approaches to data collection, assist with analyses of data and provide ongoing feedback through the final drafts of the report. Our work included reviewing policy manuals of DES, DES APS, AHCCCS, and ADHS, Arizona Administrative Code and Arizona Revised Statutes, agency websites, reports, and data files, and interviewing staff from the three key agencies and other stakeholders involved with vulnerable adults in Arizona. The following describes the specific methods as they pertain to the audit objectives.

To produce the information in Chapter One of the report, and to gain an overall understanding of each of the agencies' responsibilities related to vulnerable adults, we conducted interviews and reviewed numerous documents including policies, rules, and statutes governing agencies/entities that provide services to vulnerable adults and/or have a responsibility related to protecting vulnerable adults. Specifically:

- We reviewed policies and procedures from AHCCCS, DES - including APS, DDD, and the Long-Term Care Ombudsman Program, ADHS, and Arizona Attorney General's Office. To identify further agencies involved in the system we conducted key informant interviews with individuals from each of the three main agencies and conducted follow-up interviews as needed.
- We reviewed DES APS Investigation Policy and Procedures, and DES APS CIU Policy and Procedures. We also reviewed AHCCCS' policy and process for managing and investigating quality of care plan complaints and their policy for cross-reporting to DES APS. In addition, we reviewed ADHS policy and process for investigation licensing complaints and cross-reporting to DES APS and referrals to other agencies.
- We reviewed Arizona Revised Statutes for DES APS' statutory authority,⁸¹ the role of law enforcement agencies as mandated reporters,⁸² the Independent Oversight Committee,⁸³

⁸¹ Arizona Revised Statutes [A.R.S.] §§ 46-451 through 46-474.

⁸² A.R.S. §46-454

⁸³ A.R.S. §§ 41-3801 through 41-3804

DES Division of Developmental Disabilities,⁸⁴ the Long-Term Care Ombudsman Program,⁸⁵ and the appointment of a Public Fiduciary.⁸⁶

Our work related to Chapter Two, Strategic Direction, included determine whether there was a state-wide strategic direction for the Arizona adult protective services system that ensures the safety of vulnerable adults and establishes protocols for services after an investigation. We reviewed various agency planning documents and annual reports, conducted research, and received input from national experts on key components important for an adult protective services system, and reviewed other state adult protective service systems and programming. Specifically:

- We reviewed the Arizona State Plan on Aging for 2023-2026, DES Strategic Plans, APS annual reports, the 2020 DES APS Action Plan, the 2021 DES APS Operational Plan, and the 2023 ADHS Strategic Plan, and various Abuse & Neglect Prevention Task Force reports. We compared these documents to systems approaches and key outcomes related to improving outcomes for vulnerable adults and reducing maltreatment identified through a literature review and input from national experts.⁸⁷
- We obtained information on other states based on input from our national consultants who are experts in the adult protective services field and a review of ACL funded initiatives. We contacted Arkansas, New York, Massachusetts, and Nevada to obtain information on other APS system organizations, structures, and strategies. .⁸⁸ In addition, we reviewed information on other state APS programs that were beginning to implement strategies to address services. Our work related to Chapter Three – Accountability Mechanisms, included to assessing whether the Arizona adult protective services system had accountability mechanisms, such as supervisory reviews and independent oversight, and mechanism for producing complete and accurate data on performance and outcome measures and a system-wide performance reporting process. For example, we reviewed current agency performance reports, data elements collected and tracked from state fiscal year 2020 to 2022, reviewed the quality of the data provided

⁸⁴ A.R.S. § 36-552.

⁸⁵ A.R.S. §46-452.01.

⁸⁶ A.R.S. 14-5602.

⁸⁷<https://www.ncbi.nlm.nih.gov/books/NBK98793/>

Burnes, D. (2017). Community elder mistreatment intervention with capable older adults: Toward a conceptual practice model. *The Gerontologist*, 57(3), 409-416. doi:10.1093/geront/gnv692

Burnes, D., MacNeil, A., Nowaczynski, A., Sheppard, C., Trevors, L., Lenton, E., Lachs, M. S., & Pillemer, K. (2021). A scoping review of outcomes in elder abuse intervention research: The current landscape and where to go next. *Aggression and Violent Behavior*, 57, 101476. doi:10.1016/j.avb.2020.10147

Liu, P., Hass, Z., Stratton, S., Conrad, K. and Conrad, K. (2022) Examining Adult Protective Service Outcomes: Services Associated with the Decrease of Mistreatment Differed by Elder Mistreatment Type. *Gerontologist*, 62(9), 1359-1368. <https://doi.org/10.1093/geront/gnac040>.

⁸⁸ We were able to reach out to these states/systems directly for comment because of existing professional relationships with the national experts on our team.

by assessing its accuracy, completeness, and integrity as evident by a review of the data documentation when provided. We also made use of the National Voluntary Consensus Guidelines for evaluating and reporting on state APS program performance.

Specifically:

- We reviewed the data DES APS collects and reports against nationally recommended practices for fiscal years 2020 through 2022, and National Adult Maltreatment Reporting System data for federal fiscal years 2019-2021. In addition, although there was no unique identifier, we used a deterministic approach to matching by attempting to match AAA case-level data on managed vulnerable adults with records from a DES APS case file using a similar data item or data field. The DES APS case file data was from referrals for services for fiscal years 2020-2022. Finally, we continually reviewed the DES APS dashboard on the DES website.
- We reviewed ADHS online complaint portal data files for fiscal years 2020-2022 and annual CMS State Performance Integrated Reporting and Intelligence Tool reports. In addition, we reviewed AHCCCS performance measures and trends from their dashboard reports.
- We reviewed laws, rules, and statutes around information sharing and confidentiality for AHCCCS,⁸⁹ DES APS,⁹⁰ and ADHS.⁹¹ In addition, we also reviewed minutes, membership, schedule, and intent/charters for the Arizona State Agency Collaborative and the Agreement of Cooperation meetings.

Our work related to Chapter Four on Community Engagement, included assessing strategies for community engagement including engaging with external stakeholders such as families, vulnerable adults, and service providers. For example, we reviewed current agency community engagement activities, national guidelines, and other state adult protective services programs' approach to community engagement. Specifically, we reviewed:

- AHCCCS, DES, and ADHS websites and public dashboards.

⁸⁹ https://azahcccs.gov/Resources/guidesmanualspolicies/eligibilitypolicy/eligibilitypolicymanual/Policy/Chapter_1600_Customer_Rights/1602_Confidentiality/A_Safeguarding_Confidential_Information.htm

⁹⁰ APS Investigation Policy and Procedures Manual Chapter 4 - Confidentiality and Release of Information and Chapter 5 - Cross-reporting

⁹¹ DHS Division of Licensing Services (DLS) - Long-Term Care (LTC) Facilities Complaint/Incident Investigation Process - C. Triage and Prioritization (Referrals)

- DES APS' community-outreach log, activities, and presentations against recommended practices⁹² and examples from other states – Nevada, Massachusetts, and New York.⁹³
- DES APS' methods for selecting vulnerable adults to complete the DES APS vulnerable adult satisfaction survey, the results of that survey, and plans for incorporating feedback and continuing the survey.
- The DES APS Action Plan' (2020) which was developed through a joint effort between ADHS, APS, and stakeholder input.
- The website and social media accounts for 'Speak Up AZ!' a joint public awareness campaign to educate the public about recognizing and reporting signs of abuse, neglect, and exploitation of adults.⁹⁴

Finally, our work related to Chapter Five (see pages 53 to 59) Areas for Future Review, included identifying areas that warrant further study but could not be completed under the current review. This work included reviewing DES APS data, national data, interviewing stakeholders, surveying staff, reviewing statutes and memorandums of understanding.

⁹² Recommended best practices we reviewed included the National Voluntary Consensus Guidelines for State Adult Protective Services Systems, 2020. <https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf>.

⁹³ We reviewed other APS programs - Nevada, Massachusetts DPPC, and New York state - community engagement goals, how they track community outreach, and examples of outreach activities through our teams' national experts' contacts.

⁹⁴ The public awareness campaign includes AHCCCS, ADES APS, ADHS, and the Governor's office.

RESPONSE FROM ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM



Katie Hobbs, Governor
Carmen Heredia, Cabinet Executive Officer
and Executive Deputy Director

September 26, 2023

LeCroy & Milligan Associates, Inc.
2002 N Forbes Blvd Ste 108
Tucson, AZ 85745

Dear LeCroy & Milligan Associates, Inc.,

Pursuant to Laws 2022, Ch. 313, §55, the Arizona Auditor General was directed to engage an independent consultant to examine the current adult protective services system and consider best practices to improve the delivery of services in this state. The Arizona Auditor General hired LeCroy & Milligan Associates, Inc. to conduct this examination. As one of the entities providing services and facilitating the provision of services to vulnerable adults, AHCCCS was interviewed by LeCroy & Milligan Associates, Inc. to identify AHCCCS' role and responsibilities in the adult protective services system. AHCCCS has also reviewed excerpts of, and provided input to, the culminating final report draft, *Examining the Delivery of Services to Vulnerable Adults in the Arizona Adult Protective Services System*.

LeCroy & Milligan Associates, Inc., noted one recommendation for AHCCCS agreement in its Report; *'Recommendation 4: Continue to partner with key agencies—DES APS, AHCCCS, and ADHS should continue to find ways to partner in community engagement activities, such as Speak Up AZ!, to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults.'*

AHCCCS acknowledges that vulnerable populations are at increased risk of abuse and exploitation and these populations include individuals with disabilities. As relayed in the recommendation, AHCCCS agrees to continue its efforts with DES APS and ADHS to help ensure the health and safety of Arizona's most vulnerable citizens; to find ways to partner in community engagement activities to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults; and to foster a society that values and protects vulnerable adults in Arizona.

Sincerely,

Carmen Heredia
Cabinet Executive Officer and Executive Deputy Director

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602-417-4000
801 East Jefferson Street, Phoenix, AZ 85034

Recommendation 4: Continue to partner with key agencies—DES APS, AHCCCS, and ADHS should continue to find ways to partner in community engagement activities, such as Speak Up AZ!, to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults.

Agency response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: AHCCCS acknowledges that vulnerable populations are at increased risk of abuse and exploitation and these populations include individuals with disabilities. AHCCCS will continue its efforts with DES APS and ADHS to help ensure the health and safety of Arizona's most vulnerable citizens; to find ways to partner in community engagement activities to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults; and to foster a society that values and protects vulnerable adults in Arizona.

RESPONSE FROM ARIZONA DEPARTMENT OF HEALTH SERVICES



ARIZONA DEPARTMENT
OF HEALTH SERVICES

September 25, 2023

Craig LeCroy
LeCroy & Milligan Associates, Inc.
2002 North Forbes Boulevard, Suite 108
Tucson, AZ 85745

Dear Mr. LeCroy,

The Arizona Department of Health Services (ADHS) has provided LeCroy & Milligan Associates, Inc. with a copy of the ADHS' response to the revised final draft report, *Examining the Delivery of Services to Vulnerable Adults in the Arizona Adult Protective Services System*.

The ADHS agrees with Chapter 4, Recommendation 4. The ADHS believes it is important to protect the health and safety of vulnerable adults, especially in licensed facilities where many reside. The ADHS will continue efforts to partner with the Department of Economic Security and the Arizona Health Care Cost Containment System to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation to help protect Arizona's vulnerable adults.

If you have any questions, please contact me directly at 602.542.1181.

Sincerely,

Jennie Cunico

Jennifer Cunico
Director

Katie Hobbs | Governor

Jennifer Cunico | Director

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Health and Wellness for all Arizonans

Recommendation 4: Continue to partner with key agencies—DES APS, AHCCCS, and ADHS should continue to find ways to partner in community engagement activities, such as Speak Up AZ!, to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: The ADHS believes it is important to protect the health and safety of vulnerable adults, especially in licensed facilities where many of them reside. The ADHS will continue efforts to partner with the DES and AHCCCS to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation to help protect Arizona's vulnerable adults.

RESPONSE FROM ARIZONA DEPARTMENT OF ECONOMIC SECURITY



DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Katie Hobbs
Governor

Vacant
Director

September 27, 2023

Mr. Craig LeCroy
LeCroy & Milligan Associates
2002 North Forbes Boulevard, Suite 108
Tucson, Arizona 85745

Dear Mr. LeCroy:

On behalf of the Arizona Department of Economic Security (ADES/Department), I am pleased to respond to the report *Examining the Delivery of Services to Vulnerable Adults in the Arizona Adult Protective Services System* completed by LeCroy & Milligan Associates, Inc. (LMA) on behalf of the Arizona Office of the Auditor General (OAG) and to take this opportunity to highlight the following key points.

While the report primarily addresses a state-wide system of protections and supports for vulnerable adults in Arizona, it does not provide a clear definition of the Adult Protective Services System, and who is included. This system is broad and spans both public and nonprofit entities, each with its own specific role and set of responsibilities.

ADES' Adult Protective Services (APS) is responsible for investigating allegations of abuse, neglect, and exploitation of vulnerable adults, placing perpetrators on the APS Registry and referring clients to stabilizing services. APS has implemented numerous initiatives and improvements in many of the areas discussed in this report that have strengthened both the investigative process and the client experience. Recognizing the myriad of services and entities necessary to protect vulnerable adults, APS looks forward to working with system partners in the recommended working group. ADES further welcomes additional direction from the Governor and the Legislature as Arizona establishes a strategic direction and related accountability mechanisms for its adult protective services system.

In September 2023, the Administration for Community Living (ACL) within the U.S. Department of Health and Human Services (HHS) issued Notice of Proposed Rulemaking (NPRM) on Adult Protective Services Functions and Grant Programs. The implementation of these standards, which are largely informed by the 2020 Voluntary Consensus Guidelines for State Adult Protective Services, will drive APS' strategic direction and, in doing so, play a critical role in the system's direction. This proposed rulemaking provides considerable detail on required and recommended APS practices.

Understanding that data sharing among collaborating entities can be beneficial for both clients and systems, each of the system entities have specific responsibilities around the protection of client information. To this end, data sharing efforts will need to be carefully understood and considered by the working group in order to make informed recommendations.

We appreciate the Legislature calling for this examination of the system of protections for adults in Arizona. We also thank LMA and the OAG for your efforts to conduct this examination and for your professionalism in seeking our feedback on the written report.

Sincerely,

A handwritten signature in cursive script that reads "Angie B. Rodgers".

Angie Rodgers
Executive Deputy Director
Cabinet Executive Officer

Enclosure

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Chapter Two: Strategic Direction

Recommendation 1: Establish a working group— ADES should work with the Governor, President of the Arizona Senate, and Speaker of the Arizona House of Representatives to establish and appoint members to a working group to develop a strategic direction for Arizona's Adult Protective Services system. Specifically, to ensure working group membership adequately represents various system stakeholders, the Governor, President of the Arizona Senate, Speaker of the Arizona House of Representatives, and ADES should consider appointing 5 members each, for a total of 20 members, or appointing an alternate number of members with each appointing an equal number. When appointing working group members, the Governor's Office, President of the Arizona Senate, Speaker of the Arizona House of Representatives, and ADES could consider a wide range of stakeholders, such as representatives from AHCCCS, ADHS, and the Attorney General's Office; public fiduciaries; representatives from local law enforcement; vulnerable adult advocates; Tribal representatives; legislative members; and members from the Arizona House of Representatives' Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: ADES looks forward to working with the Governor, President of the Arizona Senate, and the Speaker of the House of Representatives to establish a working group responsible for developing a strategic direction for Arizona's system of protections of vulnerable adults.

Recommendation 2: Develop report identifying roles/responsibilities and other needs— ADES in conjunction with the working group should develop a report that identifies the working group's roles and responsibilities and identifies any authority, resources, legislation, or other action needed to ensure the working group's ongoing success in identifying and implementing the strategic direction for Arizona's adult protective services system. ADES should submit the report to the Governor, President of the Arizona Senate, Speaker of the Arizona House of Representatives, Senate and House Health and Human Services committees, Joint Legislative Budget Committee, and Arizona House of Representatives' Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults by November 1, 2024.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: Once a working group is established, ADES is committed to partnering with other members to develop a report identifying roles and responsibilities of work group members as well as any authority, resources, legislation, or other action needed to ensure the group's ongoing success. The timeliness of this report will ultimately depend on when the working group is established.

Recommendation 3: Develop a strategic direction—Once the roles and responsibilities and any needed authority, resources, legislation, or other action has been provided and/or approved, DES in conjunction with the working group should develop a strategic direction for Arizona's adult protective services system that will help ensure the safety of vulnerable adults and establishes protocols for services during and after an investigation. This should include: Evaluating how Arizona's adult protective services system can target systems beyond just the individual victim to help alleviate mistreatment risk; Determining whether a specific state agency should be assigned the responsibility of case management services to help ensure that vulnerable adults receive the services they have been referred to after a ADES APS investigation; Establishing processes, in conjunction with recommendations in Chapter Three, for measuring and reporting on vulnerable adult level outcomes, including key outcomes that will help demonstrate whether Arizona's processes are reducing maltreatment, vulnerable adult-centered, and provide services both during

and after an investigation; Considering practices from other states, including those outlined in this report; Addressing gaps outlined in this report; and Reviewing and considering whether to continue and or build upon efforts outlined in other plans, such as Report of the Abuse & Neglect Prevention Task Force (2019), Implementation and Impact of Arizona's Abuse & Neglect Prevention Task Force Recommendations (May 2022), Arizona State Plan on Aging 2023-2026 (2023), Adult Protective Services Action Plan (March 2020), ADES APS Year in Review Reports (SFYs 2020, 2021 and 2022), and ADES Annual Report (SFY 2022).

Department response: The chapter conclusion is agreed to, and a different method of dealing with the audit recommendation will be implemented.

Response explanation: ADES is committed to participating in the working group in order to ensure the safety of vulnerable adults. However, the working group, with direction from the Governor and Legislature, should set the working group's direction and priorities. ADES APS' strategic direction and perspective within this working group will also be largely determined by the federal standards currently being established by ACL.

Recommendation 4: Develop action plan for implementing strategic direction—Once the strategic direction is established, ADES in conjunction with the working group should complete the following task: Develop an action plan for implementing Arizona's strategic direction, including identifying ADES and other state agency responsibilities, policies, protocols, practices, and/or statutory changes that are needed, and critical resources and commitments that must be in place for ensuring Arizona's strategic direction can be met. The action plan should include specific tasks with estimated completion dates along with assigned responsibilities and a process to regularly review progress and modify the plan as needed.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: ADES looks forward to participating in the working group to develop an action plan for implementing the Adult Protective Services system strategic direction.

Chapter Three: Accountability Mechanisms

Recommendation 1: Identify accountability mechanisms— ADES in conjunction with the working group identified in Chapter Two, Recommendation #1, should identify accountability mechanisms that could be implemented for Arizona's adult protective services system, such as independent oversight and quality assurance processes.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: ADES agrees that accountability mechanisms for the system of protections for vulnerable adults can be established to further build upon successful APS initiatives. Successful APS initiatives include, but are not limited to, the following:

- APS has extensive quality assurance mechanisms already in place around its investigatory protocols, including ongoing quality assurance review of open investigations, real time data dashboards to identify trends and issues that need attention, and a standalone case review unit that reviews and closes all cases that are not going through the substantiation process. This case closure process was recently recognized at the National Adult Protective Services Association conference as an innovative practice that should be replicated in other states.

- The *Adult Protective Services Functions and Grant Programs* rulemaking will provide federal oversight of APS. The proposed rules specifically state that within APS, “services” includes receiving reports of abuse, neglect, and exploitation, investigating these reports, case planning, monitoring, evaluation, and other casework, and providing, arranging for, or facilitating the provision of services. ADES/APS data is currently set up to track and measure service outcomes as described in the NPRM.
- APS maintains a publically available data dashboard that includes information on allegations, caseloads, demographics, etc. This dashboard provides for transparency and accountability around APS investigations.
- Consistent with best practice, APS conducts client satisfaction surveys to capture the client’s experience and drive improvements within the program.

ADES looks forward to partnering with the working group to identify accountability mechanisms for the system of protections for vulnerable adults.

Recommendation 2: Identify and develop common, system-wide outcomes— ADES in conjunction with the working group identified in Chapter Two, Recommendation #1, should identify and develop a set of common, system-wide outcomes that can be used to assess the effectiveness of Arizona’s strategic direction, including identifying which entities will collect outcome data and how they will do so, and developing a quality assurance process for ensuring the outcome data is complete and accurate. The outcomes should include (1) reduced elder and vulnerable adult mistreatment; (2) reduced recurrence of victimization and or self-neglect; (3) service plans that are vulnerable adult-centered; and (4) vulnerable adult engagement with services during and after an investigation that alleviate mistreatment.

Department response: The chapter conclusion is agreed to and a different method of dealing with the audit recommendation will be implemented.

Response explanation: ADES looks forward to collaborating with the working group to develop system-wide outcomes for the protection of vulnerable adults that can be used to assess the effectiveness of the system’s strategic direction. Although ADES agrees that the working group should review and consider the outcomes recommended in the report, ultimately the working group should determine what specific outcome data is necessary to support Arizona’s strategic direction.

Recommendation 3: Identify system-wide performance reporting process and develop report identifying roles/responsibilities and other needs— ADES in conjunction with the working group identified in Chapter Two, Recommendation 1, should identify a system-wide performance reporting process that could compile performance and outcome information on an annual basis to assess the effectiveness of Arizona’s strategic direction. In designing the performance reporting process, the working group should resolve the data issues identified in this report, including, limitations of a lack of data on service provision; lack of unique identifiers, absence of outcome reporting between agencies, concerns with confidentiality; and lack of case management processes that may be a barrier to sharing vulnerable adult level information and reporting on aggregate outcomes for vulnerable adults. ADES in conjunction with the working group should develop a report that identifies the authority, roles and responsibilities, and resources needed to design and implement the system-wide reporting process. ADES should submit the report to the Governor, President of the Arizona Senate, Speaker of the Arizona House of Representatives, Senate and House

Health and Human Services committees, Joint Legislative Budget Committee, and Arizona House of Representatives' Ad Hoc Committee on Abuse and Neglect of Vulnerable Adults.

Department response: The chapter conclusion is agreed to and a different method of dealing with the audit recommendation will be implemented.

Response explanation: Although ADES agrees that the working group should review and consider the data issues raised in the report, ultimately the working group should design the performance reporting process. In considering system-wide outcome data, the working group will have to carefully consider confidentiality limitations around the use of Personally Identifiable Information (PII). Each entity in the system has unique requirements and restrictions around the use of its data. The working group will be best positioned to identify meaningful performance reporting processes that speak to the effectiveness of the entire adult protective services system while balancing important considerations, such as the confidentiality of information.

However, once a working group is established, DES is committed to partnering with other members to develop a report identifying roles and responsibilities of work group members as well as any authority, resources, legislation, or other action needed to ensure the group's ongoing success. The timeliness of this report will ultimately depend on when the working group is established.

Recommendation 4: Implement system-wide performance reporting process—Once the roles and responsibilities and any needed authority, resources, legislation, or other action has been provided and/or approved, ADES in conjunction with the working group should take the necessary steps to implement a system wide performance reporting process that compiles performance and outcome information on an annual basis to assess the effectiveness of Arizona's strategic direction.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: Once a working group is established, ADES is committed to partnering with other members to develop a report identifying roles and responsibilities of work group members as well as any authority, resources, legislation, or other action needed to ensure the group's ongoing success. The timeliness of this report will ultimately depend on when the working group is established.

Chapter Four: Community Engagement

Recommendation 1: Incorporate community engagement into strategic direction— ADES in conjunction with the working group identified in Chapter Two, Recommendation 1, should incorporate community engagement into the strategic direction for Arizona's adult protective services system identified in Chapter Two, Recommendation #3.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: ADES is proud of its ongoing community engagement work. In 2023, APS worked with stakeholders across the system to launch SpeakUpAZ!, a state-wide campaign to raise awareness of the abuse, neglect, and exploitation of vulnerable adults. Through collaboration with the working group, DES hopes to build on its recent successes.

Recommendation 2: Continue community engagement efforts— ADES APS should continue community engagement efforts and ensure educational materials at a minimum include the information recommended by the ACL 2020 Voluntary Consensus Guidelines for state APS systems.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: As described in the report, APS' current and ongoing community engagement activities currently align with the ACL 2020 Voluntary Consensus Guidelines for state APS Systems. APS plans to continue this work and will work with partners in the working group to ensure best practices inform all community outreach activities.

Recommendation 3: Continue satisfaction survey— ADES APS should continue its vulnerable adult satisfaction survey; expand it to include other case participants; offer a Spanish language option; continue to use feedback from the survey to improve its processes for vulnerable adults; and consider incorporating survey responses into performance reports.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: As described in the report, ADES plans to continue conducting monthly client satisfaction surveys in English and Spanish. Themes from these surveys are used to inform and improve APS practices.

Recommendation 4: Continue to partner with key agencies— ADES APS, AHCCCS, and ADHS should continue to find ways to partner in community engagement activities, such as Speak Up AZ!, to educate the public on recognizing and reporting signs of abuse, neglect, and exploitation of adults.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: ADES is proud of its ongoing community engagement work. In 2023, APS worked with stakeholders across the system to launch SpeakUpAZ!, a state-wide campaign to raise awareness of the abuse, neglect, and exploitation of vulnerable adults. Through collaboration with the working group, DES hopes to build on its recent successes.

Recommendation 5: Obtain input from vulnerable adults— ADES in conjunction with the working group identified in Chapter Two, Recommendation 1, should involve vulnerable adults and their families in the development of the strategic direction for Arizona's adult protective services system.

Department response: The chapter conclusion is agreed to and the audit recommendation will be implemented.

Response explanation: Through participation with the working group, ADES will engage vulnerable adults, their families, and supporting organizations to identify opportunities for system improvement.