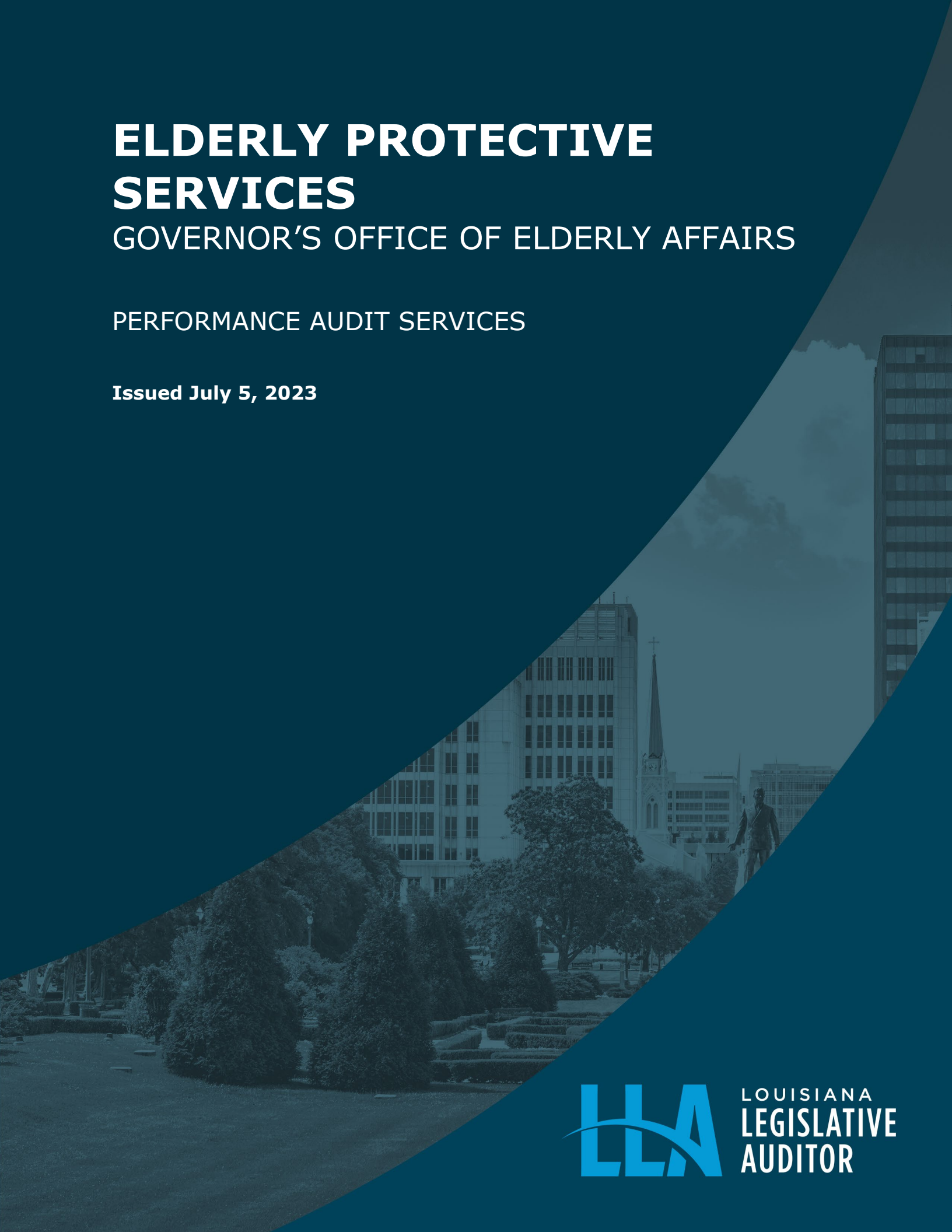
ELDERLY PROTECTIVE SERVICES

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS

PERFORMANCE AUDIT SERVICES

Issued July 5, 2023



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July 5, 2023

The Honorable Patrick Page Cortez,
President of the Senate
The Honorable Clay Schexnayder,
Speaker of the House of Representatives

Dear Senator Cortez and Representative Schexnayder:

This report provides the results of our performance audit of the Governor's Office of Elderly Affairs (GOEA). The purpose of this audit was to evaluate GOEA's oversight of cases of elder abuse and neglect in its Elderly Protective Services (EPS) program.

We found that EPS may not be receiving all reports of elder abuse and neglect because it does not answer calls outside of regular business hours, allow for online reporting, or provide information on reporting options for callers with hearing or speech impairments or language barriers.

In addition, EPS has not developed sufficient criteria to help ensure that its intake staff make consistent and appropriate decisions about which cases are eligible for assistance and which cases need to be rejected and referred to other entities when necessary.

We also found that EPS needs to develop clear, detailed guidance on what circumstances may warrant an escalated response priority for a case.

EPS did not always meet required timeframes when assigning reports of abuse and neglect or investigating and closing cases. For example, due in part to temporary policy changes in response to the COVID-19 pandemic and insufficient staffing, EPS did not assign reports for investigation within the required timeframes for 18 (19.6%) of 92 cases reviewed. In addition, EPS did not contact clients within required timeframes in 39 (42.4%) of 92 cases.

We found as well that EPS policy does not detail investigation procedures for physical abuse and neglect cases that involve a client's death. As a result, EPS did not always notify coroners when clients died during investigations or follow up on causes of death to determine whether the cases should have been forwarded to law enforcement for further investigation. During fiscal years 2018 through 2022, at least 1,949 (8.8%) of 22,172 cases closed by EPS involved client death. In

addition, unlike other states, Louisiana does not have a specialized team to review suspicious elder fatalities.

Additionally, EPS did not always develop service plans to address each problem identified during case investigations as required by policy and follow up on service plans to ensure clients received the services they needed.

We found, too, that EPS faces significant challenges, including low staffing and funding levels, high caseloads, and an ineffective data system. As a result of insufficient staffing, EPS caseworkers had an average monthly caseload of 85.6 cases during fiscal years 2018 through 2022, which is higher than those of at least 36 other states. In addition, EPS' current data system does not allow GOEA to effectively monitor for program compliance and performance. While GOEA has been working with the Office of Technology Services to develop a new system, implementation is delayed, and it is unclear whether the new system will meet all of EPS' needs.

The report contains our findings, conclusions, and recommendations. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the Governor's Office of Elderly Affairs for its assistance during this audit.

Respectfully submitted,

Michael J. "Mike" Waguespack, CPA
Legislative Auditor

MJW/aa

EPS

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Elderly Protective Services
Governor's Office of Elderly Affairs

July 2023

Audit Control # 40220018

Introduction

We evaluated the Governor's Office of Elderly Affairs' (GOEA) oversight of the Elderly Protective Services (EPS) function during fiscal years 2018 through 2022.[1] According to state law,[2] EPS is responsible for protecting elders aged 60 and above who cannot physically or mentally protect themselves and who are harmed or threatened with harm through action or inaction by themselves or by the individuals responsible for their care. EPS investigates reports of alleged abuse, neglect, exploitation, and extortion.[3]

> EPS is committed to preserving and protecting the rights of vulnerable elders in need of assistance due to abuse, neglect, self-neglect, and/or exploitation.
>
> **Source:** EPS Mission Statement

Budget and Staffing. In fiscal year 2022, EPS had a budget of approximately $6.0 million and was funded primarily by state general funds ($3.8 million or 63.3%) and federal grants ($2.2 million[4] or 36.7%). As of May 2023, EPS had 40 staff, including one program manager, four intake staff, six field supervisors, and 29 caseworkers.

Responsibilities. According to GOEA, the primary goal of the EPS program is to prevent, remedy, halt, or hinder abuse, neglect, exploitation, or extortion of individuals in need of services as defined by EPS policy and state law.[5] In order to meet this goal, EPS is tasked with the following objectives:

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

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[1] We previously evaluated EPS in February 2016; however, at that time the function was administered by the Louisiana Department of Health (LDH). The report can be found here: https://app.lla.state.la.us/publicreports.nsf/0/f782c2d62b1ec07486257f63007ce44c/$file/0000cf48.pdf?openelement&.7773098

[2] Louisiana Revised Statutes (LA R.S.) 15:1502 and 15:1503 4(a)

[3] LA R.S. 15:503 11(a)

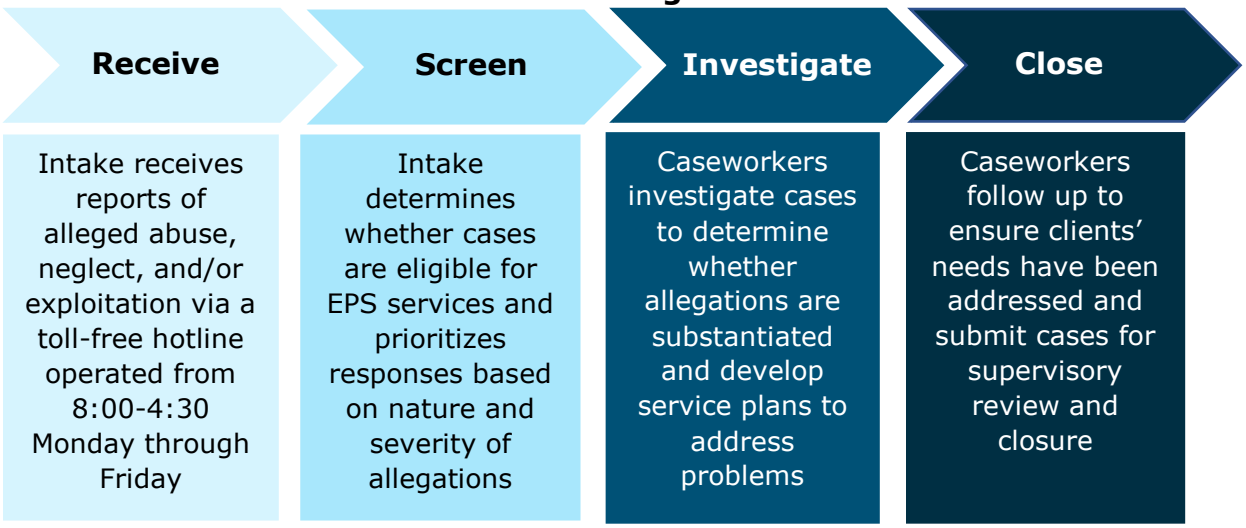
[4] Federal funding received by EPS is typically significantly lower. Funds from the American Rescue Plan Act, which is related to federal funding packages in response to the COVID-19 pandemic, accounted for 96.9% of EPS' federal funding for fiscal year 2022.

[5] LA R.S. 14:403.2 and 15:1501-1511

- Provide protective services to the individual while assuring the maximum possible degree of self-determination and dignity;
- Coordinate with other community service and health service providers to arrange and facilitate the process toward developing individual and family capacities to promote safe and caring environments for individuals in need of protection;
- Secure referral or admission to appropriate alternative living arrangements if all efforts to maintain the individual in his/her own home fail;
- Assist individuals in need of protection to maintain the highest quality of life with the least possible restriction on the exercise of personal and civil rights;
- Educate the general public regarding Elderly Protective Services and the requirements of state law.

Exhibit 1 summarizes EPS' processes for receiving, screening, investigating, and closing reports of elder abuse.

Exhibit 1
EPS Case Progression



Source: Prepared by legislative auditor's staff using information provided by EPS.

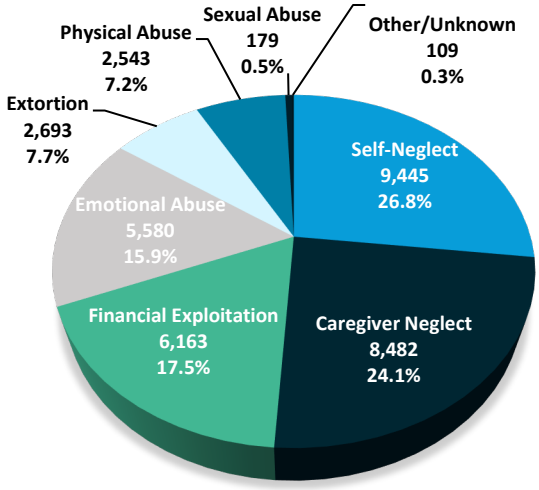
Number and Types of Cases. During fiscal years 2018 through 2022, EPS received an average of 5,188 reports of elder abuse/neglect each year and accepted 92.5% of these reports for investigation. Exhibit 2 summarizes the number of reports received and investigated by EPS each year during fiscal years 2018 through 2022.

Exhibit 2 Reports Received and Accepted Fiscal Years 2018 through 2022			
Fiscal Year	**Cases Received**	**Cases Accepted**	**% Accepted**
2018	5,858	5,528	94.4%
2019	5,560	5,196	93.5%
2020	5,087	4,769	93.7%
2021	4,411	4,008	90.9%
2022	5,024	4,491	89.4%
Total	**25,940**	**23,992**	**92.5%**
Yearly Average	**5,188**	**4,798**	**92.5%**

Source: Prepared by legislative auditor's staff using information from EPS.

The 23,992 cases accepted by EPS during fiscal years 2018 through 2022 involved 35,194 allegations,[6] with the most common being self-neglect (9,445, or 26.8%) and caregiver neglect (8,482, or 24.1%). Exhibit 3 summarizes the number and percent of allegation types for the cases accepted by EPS during fiscal years 2018 through 2022.

Exhibit 3
Reported Allegation Types
Fiscal Years 2018 through 2022



Note: EPS cases often involve multiple allegations.
Source: Prepared by legislative auditor's staff using data from the EPSM database.

To conduct this audit, we reviewed EPS policies and procedures, researched best practices, interviewed EPS employees, and analyzed EPS case data. In addition, we reviewed a selection of cases to test for policy requirements including documented case activity, supervisory reviews, service plans, and required referrals. The objective of this audit was:

To evaluate GOEA's oversight of cases of elder abuse and neglect in its Elderly Protective Services (EPS) program.

[6] EPS cases often involve multiple allegations.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains GOEA's response to this report and Appendix B details our scope and methodology.

Objective: To evaluate GOEA's oversight of cases of elder abuse and neglect in its Elderly Protective Services (EPS) program.

Overall, we found the following:

- **EPS may not be receiving all reports of elder abuse and neglect because of limitations in its process for receiving allegations. EPS does not answer calls outside of regular business hours, allow for online reporting, or provide information on reporting options for callers with hearing or speech impairments or language barriers.** According to best practices, adult protective service systems should establish multiple methods for receiving reports of alleged maltreatment 24 hours a day, seven days a week, and should have the capacity to respond to emergencies with trained personnel.

- **EPS has not developed sufficient criteria to help ensure that intake staff make consistent and appropriate eligibility decisions for cases involving financial scams, homeless clients, or cases where locations are provided but client names are unknown. In addition, EPS policy does not require that supervisory review of rejected cases be documented, and not all rejected cases were referred to appropriate entities as required.** During fiscal years 2018 through 2022, EPS rejected 1,948 (7.5%) of the 25,940 total reports received. However, since EPS did not require supervisory reviews of rejected cases to be documented, we could not determine whether EPS conducted the required reviews. In addition, we found that intake staff did not refer 21 (29.6%) of 71[6] rejected cases to the appropriate entities as required by policy.

- **While EPS policy provides some guidance on how intake staff should assign response priorities, it should develop clear, detailed guidance on what circumstances may warrant an escalated response priority. In addition, including examples of what constitutes an emergency would help intake staff comply with policy regarding referring clients who need medical attention.** We identified two cases with allegations that suggested that the client needed emergency medical attention but found no evidence that EMS contact was made or even advised by EPS.

[6] Appendix B describes the methodology we used to identify the files selected for this review and other case reviews described throughout the report.

- **EPS did not always meet required timeframes when assigning reports of abuse and neglect or investigating and closing cases. For example, due in part to temporary policy changes in response to the COVID-19 pandemic and insufficient staffing, EPS did not assign reports for investigation within the required timeframes in 18 (19.6%) of 92 cases we reviewed during fiscal years 2018 through 2022. In addition, EPS did not contact clients within required timeframes in 39 (42.4%) of 92 cases.** Timely investigations are important to ensure clients receive prompt services to protect against abuse and neglect.

- **EPS policy does not detail investigation procedures for physical abuse and neglect cases that involve client death. As a result, EPS did not always notify coroners when clients died during investigations or follow up on causes of death to determine whether the cases should have been forwarded to law enforcement for further investigation. In addition, unlike other states, Louisiana does not have a specialized team to review suspicious elder fatalities.** During fiscal years 2018 through 2022, at least 1,949 (8.8%) of 22,172 cases closed by EPS involved client death. We reviewed 21 abuse and neglect cases involving client deaths and found that the caseworkers did not notify coroners in any of these cases.

- **EPS did not always develop service plans that addressed each problem identified during case investigations as required by policy. In addition, EPS did not always follow up on service plans to ensure that clients received the services they need.** We found that EPS did not develop service plans that addressed each identified problem in 11 (19.0%) of 58 cases we reviewed during fiscal years 2018 through 2022 as required by policy, and did not develop service plans at all in three (5.2%) cases. Without developing service plans to address each client problem, EPS cannot ensure that clients receive necessary services to protect them from abuse and neglect.

- **EPS faces significant challenges in performing its required duties, including low staffing and funding levels, high caseloads, and an ineffective data system.** As a result of insufficient staffing, EPS caseworkers had an average monthly caseload of 85.6 cases during fiscal years 2018 through 2022, which is higher than those of at least 36 other states. In addition, EPS' current data system does not allow GOEA to effectively monitor for program compliance and performance. While GOEA has been working with OTS to develop a new system, implementation is delayed and it is unclear whether the new system will meet all of EPS' needs.

Our findings and our recommendations are discussed in more detail in the sections below.

EPS may not be receiving all reports of elder abuse and neglect because of limitations in its process for receiving allegations. EPS does not answer calls outside of regular business hours, allow for online reporting, or provide information on reporting options for callers with hearing or speech impairments or language barriers.

According to EPS and national organizations such as the National Center on Elder Abuse (NCEA) and the Administration for Community Living (ACL),[7] elder abuse is likely underreported, in part, because many communities lack the social supports that would make it easier for victims to report their abuse. Therefore, it is important that states develop an effective process for individuals to easily report allegations of abuse and neglect.

Although best practices recommend that states establish multiple methods to report allegations of abuse and neglect 24 hours a day, seven days a week, EPS does not operate a 24-hour hotline or allow for online reporting. EPS only receives public reports of abuse and neglect through a toll-free hotline advertised on its website that is operated by four dedicated intake staff Monday through Friday, from 8:00 a.m. to 4:30 p.m. This means that calls are not answered on weekends or state holidays which, according to EPS, are often associated with increased reports as individuals may develop concerns after visiting elderly friends or relatives. If individuals call after hours, they are directed by voicemail to leave a message or dial 911 in the event of an emergency, and intake staff return these calls the following business day.[8] However, it may be difficult for some reporters to receive EPS' return calls, such as those who are unable to answer their phones during the business hours that intake staff work. In addition, EPS occasionally receives reports via email from professionals such as banks and LDH's Adult Protective Services (APS) staff; however, EPS does not have a dedicated or advertised email address for the public to report elder abuse or neglect online. According to EPS, it does not have the technology to track the number of calls the hotline receives, including calls received after hours.

[7] ACL is an operating division of the U.S. Department of Health and Human Services that supports the needs of the aging and disability populations, and improves access to healthcare and long-term services.

[8] According to EPS, any calls received during business hours that staff are not able to answer are also directed to voicemail, and staff return these calls before the end of the day.

According to EPS, to comply with best practices *(see text box at right)* it would like to implement a 24-hour hotline and online reporting but has not been able to due to a lack of funding. As of May 2023, EPS is consulting with the Office of Technology Services (OTS) to explore more affordable online reporting options. In fiscal year 2021, EPS also obtained additional state funding to hire five additional staff, including one intake worker.[9] However, according to EPS, it had requested ten positions and does not have the funding to staff intake positions outside of normal business hours. To better justify its requests for additional staff, EPS should track its call volume, including how many messages are left outside of normal business hours.

According to ACL, adult protective service systems should establish multiple methods for receiving reports of alleged maltreatment 24 hours a day, seven days a week and should have the capacity to respond to emergencies with trained personnel. A 2012 National Association of States United for Aging and Disabilities (NASUAD) survey found that 75% of states had intake lines for reporting suspected abuse that were available 24 hours a day, 68% of which were fully staffed during that time.

EPS does not provide information on reporting options for callers with hearing or speech impairments or language barriers. ACL recommends that reporting mechanisms be fully accessible to reporters who require additional services, such as augmentative communication devices for reporters with hearing impairments or translation services for reporters who do not speak English. While EPS intake staff are not equipped with augmentative communication devices or internal translations services, they can receive reports through a public telecommunication service called Louisiana Relay which offers toll-free numbers for text telephone, voice or hearing carry over, and Spanish translation services.[10] Other states such as Texas, Massachusetts, and Illinois have similar relay services and advertise this number on their adult protective services websites as an option for reporters who are deaf, deaf-blind, hard of hearing, or speech-disabled. However, EPS does not advertise this reporting option which may prevent it from ensuring that it receives as many reports as possible.

Recommendation 1: GOEA should continue to seek additional funding to fund staff positions necessary for 24-hour report intake.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will continue to seek additional funding in order to fund a 24-hour report line. GOEA recognizes this is considered best practices on a national level but is not able to provide this service due to budget constraints. See Appendix A for GOEA's full response.

Recommendation 2: GOEA should expand its reporting methods by dedicating and advertising a general EPS email address for filing reports of suspected elder abuse, while continuing to develop and implement an online reporting option.

[9] GOEA allocated $484,519 from an $814,509 increase in state general funds for the additional positions.
[10] www.larab.org

Summary of Management's Response: GOEA did not agree with this recommendation and stated that in establishing an open email for reporting, the agency could potentially be exposed to some liability. In addition, GOEA stated that it is not able to monitor the information being reported and, in many instances, it is very difficult to contact individuals via email to authenticate the information reported. See Appendix A for GOEA's full response.

Recommendation 3: GOEA should track the number of calls the EPS hotline receives, including calls received after hours, so that it can appropriately staff the hotline.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will begin tracking the number of calls received on the EPS hotline. However, GOEA stated that it is important to note that it does not have the ability to track calls that are not answered or calls where no voicemail is left. See Appendix A for GOEA's full response.

Recommendation 4: GOEA should advertise the Louisiana Relay service on its website to ensure that EPS reporting is accessible for all individuals, including those who are hearing-impaired or do not speak fluent English.

Summary of Management's Response: GOEA agreed with this recommendation. See Appendix A for GOEA's full response.

EPS has not developed sufficient criteria to help ensure that intake staff make consistent and appropriate eligibility decisions for cases involving financial scams, homeless clients, or cases where locations are provided but client names are unknown. In addition, EPS policy does not require that supervisory review of rejected cases be documented, and not all rejected cases were referred to appropriate entities as required.

EPS policy directs intake staff to screen received reports and determine whether clients are eligible for EPS services. Clients who are at risk due to abuse or neglect occurring in an unlicensed setting[11] are considered eligible for EPS services if they are at least 60 years of age and are unable to manage their own affairs or prevent the abuse or neglect. EPS policy requires all case activity, including

[11] Reports alleging abuse of elders while residing in licensed long-term care facilities should be made or forwarded to GOEA's Louisiana Ombudsman Program, which investigates reports of abuse occurring in long-term care facilities.

eligibility determinations to be documented in the Elderly Protection Services Management System (EPSM). According to EPS, all rejected cases must be reviewed by the intake supervisor, and if necessary, EPS refers certain rejected cases to other entities, such as LDH and law enforcement, for further investigation. Examples of rejected cases involved clients who lived out of state, clients whom EPS deemed capable to manage their own affairs, and preventative situations where reporters felt that abuse or neglect could potentially occur.

EPS' case eligibility criteria is not sufficient to ensure eligibility determinations are made consistently and appropriately for cases involving financial scams, homeless clients, or cases where locations are provided but client names are unknown. EPS policy requires that intake workers document case rejections, but does not provide clear eligibility criteria for all types of abuse. For example, financial exploitation[12] *(see text box at right)* is one of the reportable abuse types that state law[13] tasks EPS with investigating, and was the third most common allegation type in cases handled by EPS during fiscal years 2018 through 2022 as shown in Exhibit 3. However, EPS policy does not include sufficient criteria to guide intake workers' decisions about accepting or rejecting these cases. According to EPS, some financial exploitation cases are beyond the scope of EPS services, especially in elaborate scams where perpetrators are unknown or are overseas. We reviewed 30 rejected cases that involved financial exploitation and found that the documented rejection reasons provided for four (13.3%) of the cases were not consistent with eligibility criteria in EPS policy or with the determinations made for other similar financial exploitation cases. These financial exploitation cases included rejection reasons such as "scam" or "fraud," despite federal law[14] including fraudulent acts or processes in its definition of financial exploitation. According to EPS, the novelty and complexity of these types of cases have made it difficult to develop criteria to guide eligibility determinations on financial scam cases.

Financial exploitation occurs when a person, the "exploiter", including a caregiver, intentionally takes, spends, or uses money or resources of a vulnerable person, without some kind of valid permission.

Other states such as Texas, Florida, and North Carolina have established detailed criteria concerning the eligibility of various financial exploitation allegations. These states' policies explain and provide examples of the specific types and conditions under which reports of financial exploitation are eligible for investigation. For example, Texas specifies the difference between theft and financial exploitation, and Florida specifies that exploitation may or may not result in loss for the client. Both states provide examples of these scenarios.

[12] Our January 2019 performance audit evaluated EPS' efforts to address elder financial exploitation. The report can be found here: https://app.lla.state.la.us/publicreports.nsf/0/df6ec01945b385b58625838b0080fb86/$file/0001b96a.pdf?openelement&.7773098

[13] LA R.S. 15:1503

[14] 42 U.S.C.A. § 3002

We found additional case rejections where EPS policy did not include criteria to support the documented rejection reasons. For example, we reviewed a rejected self-neglect case involving a homeless client that did not have a home address, despite the reporter providing the client's telephone number and location where he usually parked his car. According to EPS, it has an informal policy of rejecting cases when addresses are not provided because the client would be considered "unable to locate." In addition, responding to homeless cases can be dangerous to caseworkers, and EPS does not have the resources to search for clients without home addresses. However, exceptions may be made when the allegations are egregious and the client can regularly be found at a specific location or be contacted via phone.

In addition, we found two cases where EPS did not investigate allegations of caregiver neglect because, despite providing locations for multiple clients, the potential clients' names were not provided. According to EPS, when multiple clients are involved in a report, it must open separate investigations for each client which requires that the clients' names be provided. However, EPS stated that they normally investigate reports involving multiple, unnamed clients by sending caseworkers to the provided location to gather the names of clients. It is important that EPS' eligibility criteria be detailed and formalized to ensure that cases are accepted or rejected in a consistent and appropriate manner. Formalizing eligibility criteria for homeless clients or unnamed clients would help EPS to ensure that these cases are accepted or rejected consistently and appropriately.

According to EPS, the intake supervisor is required to review all rejected cases; however, these reviews are not required to be documented. During fiscal years 2018 through 2022, EPS rejected 1,948 (7.5%) of the 25,940 total reports received. However, since EPS does not require that supervisory reviews of rejected cases be documented, we could not determine whether EPS conducted the required reviews. In addition, unlike other programs such as APS that have a dedicated supervisor for the intake function, EPS does not, as discussed later in this report. Instead, the duties of the intake supervisor, including reviewing rejected cases, are absorbed by a staff member with broader program responsibilities. It is important that EPS document its review of case rejections to ensure all rejected cases are reviewed and that eligible clients are offered protection and ineligible clients are referred to the appropriate entity when necessary.

Intake staff did not refer 21 (29.6%) of 71 rejected cases we reviewed to the appropriate entities as required by policy. While intake workers must reject certain cases because the alleged victims are ineligible for EPS services, it may be necessary to refer these cases to another entity for further investigation. For example, EPS policy requires cases involving allegations of abuse of clients under the age of 60 to be referred to LDH's APS and abuse of elderly clients by staff within a licensed setting such as nursing home to be referred to GOEA's Louisiana Ombudsman Program. In our January 2019 report, we recommended that GOEA clarify its policies regarding referrals of rejected financial exploitation cases; EPS policy now requires that rejected cases be referred as

necessary, such as to a law enforcement entity. However, intake staff did not refer 21 (29.6%) of 71 rejected cases we reviewed to the appropriate entities, including APS and law enforcement.

Recommendation 5: GOEA should formally establish eligibility criteria for cases involving financial exploitation, homeless clients, and unnamed clients residing in a known location, and ensure eligibility determinations for these cases are made consistently and appropriately.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will begin working to update the policy. See Appendix A for GOEA's full response.

Recommendation 6: GOEA should ensure that all rejected cases are reviewed and require that these reviews be documented.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will explore options to make adjustments in the Intake Department to designate one staff person to review all rejected cases. See Appendix A for GOEA's full response.

Recommendation 7: GOEA should ensure that rejected cases are referred to other entities when necessary in accordance with policy.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will continue to monitor rejected cases to ensure those cases are referred appropriately. See Appendix A for GOEA's full response.

While EPS policy provides some guidance on how intake staff should assign response priorities, it should develop clear, detailed guidance on what circumstances may warrant an escalated response priority. In addition, including examples of what constitutes an emergency would help intake staff comply with policy regarding referring clients who need medical attention.

As intake staff receive eligible reports of abuse or neglect, they assign priority levels based on the level of risk associated with allegations. Response priorities include high, medium, and low and require that investigators respond within 24 hours, five working days, or 10 working days of case assignment, respectively. During fiscal years 2018 through 2022, EPS determined that 2,621 (10.9%) of accepted cases were high priority cases. Exhibit 4 summarizes EPS'

response priority criteria, as well as the number and percent of cases by priority assignment during fiscal years 2018 through 2022.

Exhibit 4
Reports Accepted by Response Priority
Fiscal Years 2018 through 2022

Response Priority	Response Time	Description	Examples	Number of Cases	Percent of Cases
High	Within **24 hours** of case assignment	Allegations that the client has suffered serious harm or serious physical injury which, if left untreated, may result in permanent physical damage or death	• Physical and sexual abuse • Severe injury/harm • Life sustaining medication or treatment is not administered	2,621	10.9%
Medium	Within **five working days** of case assignment	Allegations that the client is at risk of imminent serious physical injury or harm	• Inadequate attention to physical needs • Self-abusive behavior	15,117	63.0%
Low	Within **ten working days** of case assignment	Reports that do not involve risk of serious physical injury or harm	• Verbal and emotional abuse • Safety hazards • Housing and healthcare concerns	6,254	26.1%
			Total	**23,992**	**100%**

Source: Prepared by legislative auditor's staff using information from EPS.

While high priority cases require caseworkers to respond within 24 hours regardless of EPS business hours, medium and low priority timeframes are based on working days. This means that if a medium priority case is received after Monday, the caseworkers may not first respond for as many as seven calendar days until the following Monday, and sometimes longer in cases of office closures or holidays. Given the amount of time that may pass before caseworkers must respond to low and medium cases, it is important that intake workers thoroughly evaluate risks when assigning priority levels.

While EPS policy provides some guidance on priority assignment, it does not provide clear, detailed guidance for cases that involve circumstances that warrant an escalated priority response. For example, EPS policy prescribes medium priority assignment for cases involving allegations of inadequate or excessive heat. According to EPS, in cases where temperatures are dangerous, intake workers may assign them as medium priority but escalate the response deadline to be earlier than five working days. However, EPS policy does not include criteria for escalating the response priority to help ensure that intake workers consistently assign priorities. For example, we found a neglect case involving allegations that the client was struggling to attend to her basic needs and did not have heat in her home despite freezing temperatures. However, intake did not escalate this case to high priority or assign medium priority with a shorter response deadline. Despite the five-day deadline, a caseworker did not attempt to

contact the client for 13 days although temperatures dropped as low as 17 degrees for the client's area.

According to EPS, staff also follow informal response priority guidance related to certain neglect allegations such as those involving clients being left in feces and urine for extended periods of time. While such reports are typically considered to be medium priority, EPS stated that these cases should be escalated to high priority when certain circumstances are present. For example, if the client has no one to assist them, or if a person providing assistance, such as a home health provider, does not visit often. However, intake staff are not directed by EPS policy or the form used by intake workers during calls to consider this information when determining response priority. In addition to the case described in the text box, we found other cases where key information did not escalate response priority as it reasonably should have. For example, one case with neglect allegations involving parts of the client's body turning black was assigned medium priority, and more than seven months passed before the caseworker attempted to contact the client.[15]

> We found one case with allegations that the client was disabled, unable to care for herself, and lived alone; was incontinent, had feces in her bed, fungus growing on her skin, and her home was infested with bedbugs; would yell to apartment neighbors for help; and had a sitter that only came every two weeks. This case was categorized as medium priority and the caseworker did not attempt to contact the client for seven days.

EPS should expand its policy and training to provide more guidance and examples of when priority assignment should be escalated. Other protective service programs specify certain exceptions in priority assignment to address cases that may not require a response within 24 hours but should be responded to in less than five working days. For example, APS policy requires all cases of caregiver neglect reported against providers[16] to be assigned as high priority. West Virginia's APS program requires face-to-face response within 72 hours for cases that did not warrant a 24-hour response timeframe but included circumstances severe enough that an emergency situation could result without prompt investigation.

We found at least two cases that appeared to warrant a call to Emergency Medical Services (EMS) but intake staff did not contact EMS. EPS policy states that if at any point it is revealed that the victim is seriously injured and/or in present danger, the intake specialist must immediately contact emergency services and follow up to determine if emergency services have been provided. While we did note instances of intake notifying law enforcement when reports involved criminal allegations, we found at least two cases that included allegations that indicated the person was in present danger and warranted a call to EMS but there was no documentation to confirm that the call was made or even advised to the reporter. In one of these cases, the reporter alleged that a client who typically lives alone was suicidal and had been actively trying to overdose on prescription medications. The reporter, a home health worker, had suggested that

[15] The caseworker did reach out to the reporter early in the case.
[16] Providers include home health or hospice agencies, hospitals, or nursing facilities.

the client receive emergency care but the client's family refused to call EMS and the client was refusing to go to the emergency room. While this case was assigned as high priority, there is no documentation of intake staff reporting this emergency to EMS.

Recommendation 8: EPS should formalize its policies on response priority escalation and ensure they include sufficient details and examples to guide response priority determinations.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will begin working to update the policy. See Appendix A for GOEA's full response.

Recommendation 9: EPS should provide training to staff on response priority policies and help ensure that they assign response priorities that comply with policy and are consistent.

Recommendation 10: EPS should provide training to intake staff on identifying situations that warrant emergency medical services and ensure that intake staff report medical emergencies when necessary.

Summary of Management's Response: GOEA agreed with these recommendations and stated that it will provide additional training. See Appendix A for GOEA's full response.

EPS did not always meet required timeframes when assigning reports of abuse and neglect or investigating and closing cases. For example, due in part to temporary policy changes in response to the COVID-19 pandemic and insufficient staffing, EPS did not assign reports for investigation within the required timeframes in 18 (19.6%) of 92 cases we reviewed during fiscal years 2018 through 2022. In addition, EPS did not contact clients within required timeframes in 39 (42.4%) of 92 cases.

According to the National Adult Protective Services Association (NAPSA) Minimum Practice Standards, APS programs should conduct and complete investigations in a timely and efficient manner. Timely investigations are important to ensure clients receive prompt services to protect against abuse and neglect. The advanced age of EPS clients also increases the importance of timely investigations as client deaths may occur during delays in the investigation. EPS has established required timeframes in policy. We reviewed a selection of cases that were received during fiscal years 2018 through 2022 to determine whether EPS assigned cases,

contacted clients, completed the investigations, and closed the cases timely as required by policy.

EPS did not assign reports for investigation in accordance with policy in 18 (19.6%) of 92 reviewed cases. EPS policy requires intake to assign high priority cases to caseworkers within the same business day and medium and low priority cases by the following business day. We reviewed case assignment timeliness in 92 cases and found that 18 (19.6%) were not assigned to caseworkers within the required timeframes. Further, nine (9.8%) of these cases were not assigned within 30 days, including two financial exploitation cases that were received in December of 2020 but were not assigned until February 2023.

EPS did not contact clients in accordance with required timeframes in 39 (42.4%) of 92 cases we reviewed. EPS policy requires investigators to contact clients within 10 business days for low priority cases, five business days for medium priority cases, and 24 hours for high priority cases. As recommended by NAPSA, EPS normally requires client contact to involve home visits for all accepted investigations *(see text box at right)*. According to EPS, it temporarily stopped conducting face-to-face investigations of all cases, including high risk cases to comply with government mandates during the COVID-19 pandemic and to prevent the spread of illness between caseworkers and vulnerable clients. Instead, EPS investigated these cases via telephone or, for high priority cases, referred them to law enforcement for a home visit.

Home visits are important because they:

- Allow caseworkers to assess the client in their physical environment to identify potential hazards, lack of resources, and/or evidence of abuse and neglect
- May reveal critical client needs, safety issues, and types of maltreatment (e.g., insufficient food, fall risks, or bruises not mentioned by the reporter)
- Allow caseworkers to ensure that client interviews are not conducted in the presence of alleged perpetrators

Source: NAPSA and EPS

We reviewed 92 cases that EPS received during fiscal years 2018 through 2022 and found that the caseworker did not attempt to contact[17] the client within the required timeframe in 39 (42.4%) cases and did not document any attempts in eight (8.7%) cases. According to EPS, some cases could not be appropriately investigated without face-to-face visits so it implemented a temporary policy to keep these cases open until an appropriate investigation or follow-up could be performed. However, we found at least two cases that, according to the case log, were closed because an appropriate investigation could not be performed "due to COVID-19." These cases involved allegations of emotional abuse, financial exploitation, and self-neglect.

We reviewed a selection of 77 closed cases and found that there was no documentation of caseworker activity or supervisory review for more than 60 days in 63 (81.8%) cases, 30 (39.0%) with lapses of more than six months, and 10 (13.0%) with lapses of more than a year. Caseworkers

[17] Because GOEA allowed exceptions to face-to-face contact requirements after the onset of the COVID-19 pandemic, we included virtual attempts to contact clients for these cases.

document their case activity, which typically includes attempts to contact clients, information obtained during interviews with clients and other relevant individuals, services offered, and case outcomes, in EPSM log notes. According to EPS, while some cases may be complex and require more time to investigate, caseworkers should document activity at least every 30 days and supervisors should monitor case activity and hold staffing sessions with the caseworker when there is no activity for 30 days. In addition to delays in protecting clients, there is increased risk with inactive cases that elderly clients may die either from abuse and neglect or natural causes before a thorough investigation has been performed.

In 15 (19.5%) of the 77 cases we reviewed, the client died during periods of case inactivity.[18] We found that in one high priority case that involved allegations of physical abuse, the client was killed during the 12 months the case was inactive and the alleged perpetrator was charged with second degree murder. According to EPS policy, caseworkers are required to make and document "good faith" efforts to locate and protect the adult. According to EPS, "good faith efforts" include actions such as at least three attempts to establish contact with the client and consulting with neighbors, law enforcement, and family members on the client's whereabouts. Although this high priority case required a 24-hour response, the caseworkers did not attempt to make first contact for 21 days. After a second unsuccessful attempt to contact the client, case notes mentioned a planned third attempt. However, this case remained inactive for a year until the supervisor updated the case notes with details about the client's death and closed the case.

During fiscal years 2018 through 2022, EPS did not meet its goal of closing cases within 120 days in 12,873 (58.1%) of 22,172 cases, with 6,104 (27.5%) cases remaining open for 180 days or more.[19] According to EPS, its goal is to close cases within 120 days. However, several factors can cause delays in case closures, including inadequate staffing levels, complex cases that require lengthy investigations and additional follow-up, and recently, restrictions imposed due to the COVID-19 pandemic. While some delays may be unavoidable, EPS policy requires supervisors to monitor for case progress to ensure that caseworkers are making necessary progress on assigned cases and to document justification when cases are not closed within 120 days. As part of this monitoring, EPS stated that supervisors typically leave notes in the case log to prompt caseworkers to perform and document necessary activities. However, we reviewed a selection of 56 cases that were open for more than 120 days and found no supervisory notes addressing the delay in the case closure or prompting the caseworker to progress toward case closure in 22 (39.3%) cases.

Supervisors are required by policy to perform and document in-depth case reviews prior to closing cases; however, we found that these reviews were not always documented and thorough. According to EPS, supervisors conduct these reviews to ensure that cases have been handled in accordance with

[18] Not all of these deaths were related to the allegations received by EPS.
[19] According to EPSM data, as of November 1, 2022, EPS closed 22,172 (85.5%) of 25,940 cases received during fiscal years 2018 through 2022.

policy. However, supervisors are not provided with a standardized tool to guide their reviews which could help ensure that they identify any missing or inaccurate case information. It is important that any errors in case data are identified and corrected because these statistics can help EPS understand the needs of clients throughout the state and areas of improvement for EPS. In addition, reviewing accurate case outcome data such as case dispositions[20] and comparing pre- and post-risk assessment scores can help EPS evaluate the impact of its services and identify areas for improvement.

We reviewed EPSM log notes for 142 cases and found that the supervisory review was not documented in 23 (16.2%) cases before they were closed. While 119 (83.8%) of these closed cases did include documentation of supervisory review, not all documentation errors were corrected. For example, while policy requires dispositions to be provided for all closed cases, we reviewed 28 closed cases and found that supervisors signed off on 18 (64.3%) cases that did not have dispositions. Although we did not find instances where these documentation errors affected the outcome of investigations, these errors affect EPS' ability to analyze the needs of clients and determine if any program improvements could be made. According to EPS, it is challenging for supervisors to perform timely and thorough case closure reviews because, in addition to supervisory duties, they often must also investigate cases to mitigate insufficient staffing levels. In addition, supervisors are required to monitor multiple regions because EPS covers nine regions but only has six supervisors.

Recommendation 11: EPS should ensure that staff comply with timeline requirements for assigning cases, contacting clients, documenting case activity, and closing cases.

Recommendation 12: GOEA should ensure that supervisors perform and document supervisory case reviews for all cases prior to case closure as required by policy.

Summary of Management's Response: GOEA agreed with these recommendations and stated that it will provide additional training. See Appendix A for GOEA's full response.

Recommendation 13: GOEA should develop a standardized tool to guide supervisors during case reviews to help ensure that they identify all missing or inaccurate case information.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will provide additional training. In addition, GOEA stated that the new system will include system checks prior

[20] Dispositions are used to indicate the outcome of an investigation such as whether the report allegations were substantiated or whether the client could not be located or died before the case could be investigated.

to case closure to ensure all required fields are completed. See Appendix A for GOEA's full response.

EPS policy does not detail investigation procedures for physical abuse and neglect cases that involve client death. As a result, EPS did not always notify coroners when clients died during investigations or follow up on causes of death to determine whether the cases should have been forwarded to law enforcement for further investigation. In addition, unlike other states, Louisiana does not have a specialized team to review suspicious elder fatalities.

Given the advanced age of EPS clients, client death may naturally occur during the course of an investigation. While EPS policy does not detail investigation procedures for physical abuse and neglect cases that involve client death, according to EPS, when a client dies and abuse or neglect was alleged, caseworkers are required to notify coroners of the allegations so that the information can be considered when determining cause of death. EPS stated that caseworkers are then required to determine whether abuse or neglect may have contributed to the death by reviewing cause of death information provided by medical professionals such as hospital staff and coroners, and refer the case for criminal investigation if necessary.

During fiscal years 2018 through 2022, at least 1,949 (8.8%) of 22,172 cases closed by EPS involved client death;[21] we reviewed a selection of 21 abuse and neglect cases involving client deaths and found that the caseworkers did not notify coroners in any of these cases. Further, we found that EPS did not document an official cause of death in 11 (52.4%) of the 21 cases. Because EPS did not consistently determine whether abuse or neglect may have been related to the client's death, we could not determine whether EPS should have referred any of the cases to law enforcement for further investigation, as required by policy. However, we reviewed death certificates for seven cases and found that causes of death in three (42.9%) appeared to be related to the allegations of abuse or neglect received by EPS. For example, we found a caregiver neglect case involving allegations that a caregiver was not performing wound care for a bedbound client with a severe foot wound. Eleven months after this case was assigned and no case activity was documented, the caseworker noted the discovery of an obituary indicating that the client died nine months prior. This case was closed with a note by the supervisor that the caseworker did not thoroughly investigate the case, but there was no documentation that the caseworker or

[21] These cases had a "deceased" closure reason in EPSM; however, there may be additional cases in which a client died during the investigation but the case was closed with a different closure reason.

supervisor obtained the client's cause of death. We obtained the death certificate and found that the client died of sepsis, respiratory failure, and an infected foot wound. These fatal conditions appear to be directly related to the allegations of caregiver neglect that were originally reported to EPS. However, EPS did not investigate this client's cause of death and determine whether the case should have been forwarded to law enforcement for further investigation.

Unlike other states, Louisiana does not have a specialized team to review suspicious elder fatalities. It is important that thorough investigations are performed when elder deaths involve suspicious circumstances because even if elder death is naturally more imminent, it may not have occurred as soon or in a given manner without abuse or neglect. Further, according to NAPSA, research increasingly indicates that abuse, neglect, and exploitation may lead to premature death among older adults. While protective service programs and law enforcement are key entities responsible for investigating these deaths, NAPSA, the Department of Justice's Office for Victims of Crime (OVC), and the American Bar Association Commission on Law and Aging (ABA-COLA) recommend that states also establish Elder Abuse Fatality Review Teams (EA-FRTs). EA-FRTs are similar to fatality review teams for deaths linked to child abuse and domestic violence, both of which have been established in Louisiana.[22]

According to ABA-COLA and OVC, EA-FRTs seek to improve systems that caused, contributed to, or failed to prevent deaths and/or recommend or support law enforcement investigation and prosecution of alleged perpetrators. In addition, EA-FRTs send a message that premature or unexplained deaths of elders will be taken as seriously as those of younger adults or children. According to NAPSA and NASUAD, as of 2012, 20 states had elder fatality review teams in place. Forming a specialized team to review suspicious elder deaths in Louisiana could help to ensure that fatal cases of elder abuse and neglect are appropriately investigated.

> **Recommendation 14:** EPS should formally establish policies detailing investigation procedures such as coroner notifications, obtaining cause of death, and referring cases to law enforcement when clients die during investigations of physical abuse or neglect.
>
> **Summary of Management's Response:** GOEA agreed with this recommendation and stated that it will begin working to update the policy. See Appendix A for GOEA's full response.
>
> **Matter for Legislative Consideration:** The legislature may wish to consider establishing an Elder Abuse Fatality Review Team to further review suspicious elder deaths in Louisiana.

[22] LA R.S. 40:2019 and LA R.S. 40:2024.3

EPS did not always develop service plans that addressed each problem identified during case investigations as required by policy. In addition, EPS did not always follow up on service plans to ensure that clients received the services they need.

As caseworkers identify problems that clients face during investigations, they are required by policy to develop and document service plans that address each issue, and then follow up on the plans to ensure that clients receive specified services. According to ACL, the overall objective of service plans is to improve client safety, prevent maltreatment from occurring, and improve the client's quality of life. Service plans can include interventions such as helping the client to obtain a restraining order against perpetrators, seek medical treatment, or acquire necessities such as food, shelter, or utilities. In addition, ACL states that the service plan should be completed prior to closing the case, meaning the client's situation should be stabilized, safety issues resolved or mitigated, and client goals achieved to the extent feasible. Exhibit 5 contains statistics on the outcomes and service plan status of cases closed by EPS during fiscal years 2018 through 2022.

Exhibit 5
Reports by Case Outcome
Fiscal Years 2018 through 2022

Closure Reason	Description	Number of Cases	Percent of Closed
Unsubstantiated	No services necessary as allegations are not substantiated	7,179	32.3%
Services complete	Service plan implemented and client is safe or risk has been reduced as much as possible	3,765	17.0%
No longer at risk	Danger or risk has been removed without a service plan or EPS service intervention	3,458	15.6%
Services refused	Client has capacity and has refused services	2,279	10.3%
Deceased	Client is deceased and the death is unrelated to criminal allegations	1,949	8.8%
Referral to another agency	Client's situation can be improved with additional services from other agencies which the client has been referred	754	3.4%
Moved	Client has moved and EPS does not have an updated address	305	1.4%
Services no longer desired	Danger or risk has been removed without a service plan or EPS service intervention	65	0.3
Other	Examples include but are not limited to cases where EPS could not investigate because the client could never be located or cases that were initially accepted but later closed due to ineligibility	2,418	10.9%
	Total Closed	**22,172**	**100%**

Source: Prepared by legislative auditor's staff using case closure reasons documented in EPSM.

We found that EPS did not develop service plans that addressed each identified problem in 11 (19.0%) of 58 cases we reviewed during fiscal years 2018 through 2022 as required by policy, and did not develop service plans at all in three (5.2%) cases. For example, EPS investigated a case where a client had been hospitalized because he was unable to care for himself, had a gangrenous body part, and was missing dialysis appointments. The investigation revealed that the client was having difficulty obtaining placement for long-term care, but EPS did not develop a service plan to address the client's needs. EPS eventually closed the case after being informed that the client had been transferred to a nursing home and was receiving dialysis, but not because of any effort on EPS' behalf. Without developing service plans to address each client problem, EPS cannot ensure that clients receive necessary services to protect them from abuse and neglect.

We also found that EPS closed seven (13.0%) of 54 cases we reviewed without adequately following up on developed service plans. One case we reviewed involved allegations that a client was HIV positive, refusing to take her medication, and had swollen and black legs. During the investigation, the caseworker learned that the client did not have access to HIV medication, so the service plan included an agreement by the caregiver to seek medical attention for the client. However, the caseworker did not follow up to ensure that the caregiver complied with the agreement and that the client received proper medical attention before closing the case 25 days later. By closing cases without adequate confirmation that clients are receiving services as planned, clients may continue to experience abuse and neglect.

Recommendation 15: EPS should ensure that caseworkers are developing and documenting service plans for all cases that address all issues identified, as required by policy.

Recommendation 16: EPS should ensure that caseworkers follow up on all service plans prior to closing cases to ensure that clients receive services as planned, as required by policy.

Summary of Management's Response: GOEA agreed with these recommendations and stated that it will provide additional training. See Appendix A for GOEA's full response.

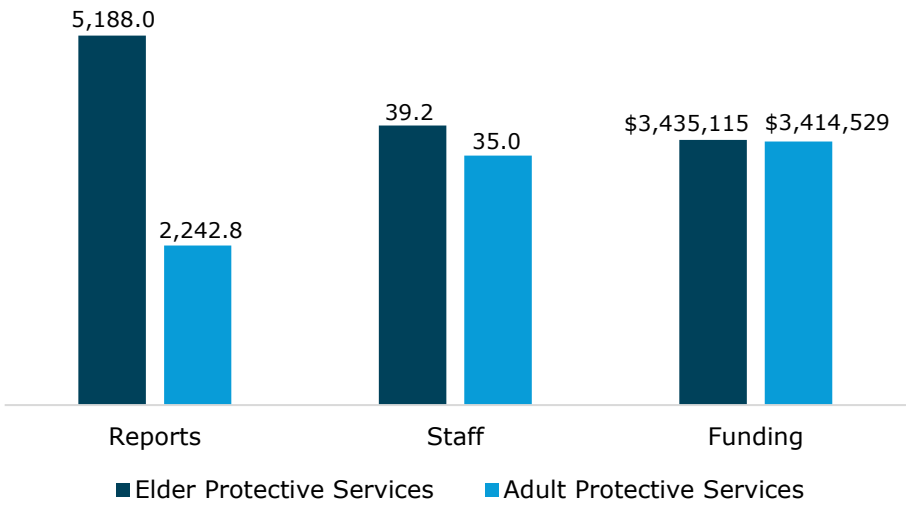
EPS faces significant challenges in performing its required duties, including low staffing and funding levels, high caseloads, and an ineffective data system.

As discussed throughout the report, we identified areas for improvement in EPS intake, investigation, and monitoring procedures. In each area, we found that staffing levels, which are directly affected by funding levels, likely contributed to the issues. Specifically, adequate staffing is required to receive reports and ensure timely investigations, but sufficient funding is required to secure and maintain adequate staffing. In addition, an outdated data system has limited EPS' ability to manage and monitor the program.

When comparing average annual report volume, staffing, and funding levels to its counterpart APS, EPS received an average of 131.3% more reports each year but only had 12.0% more staff and 0.6% more in budgeted funding than APS during fiscal years 2018 through 2022. While at least 39 other states have single programs that provide protective services to all vulnerable adults, including elderly adults, Louisiana has a bifurcated system for adult protective services. APS within LDH provides services to adults aged 18 to 59 and EPS within GOEA serves elders aged 60 and above. Since most states have combined programs, we compared the volume report, staffing, and funding of APS

and EPS.[23] While the two programs provide similar services to vulnerable adults just with different client age groups, we found that when accounting for report volume between EPS and its counterpart APS, staffing and budgeted[24] funding levels of EPS are not proportional. In other words, despite EPS receiving an average of 2,945.2 (131.3%) more reports than APS each year during the same five-year period, EPS only averaged 4.2 (12.0%) more staff than APS and $20,586 (0.6%) more budgeted funding each year. Exhibit 6 compares average report volumes, staffing levels, and budgeted funding amounts for EPS and APS during fiscal years 2018 through 2022.

Exhibit 6
Comparison of Average Annual Report Volume, Staffing, and Funding* for EPS and APS
Fiscal Years 2018 through 2022



* Budgeted funding amounts do not include temporary funding associated with federal COVID-19 relief.
Source: Prepared by legislative auditor's staff using information provided by LDH and GOEA.

APS staffing includes six more administrative positions than EPS to assist in overall program monitoring. Both programs have a program manager, direct supervisors, and a program quality monitor, but APS staffing includes five additional managers and an administrative assistant. In contrast, the EPS program manager, who is responsible for overseeing a larger program than APS as shown in Exhibit 6, must also serve as the intake manager. Further, while EPS' program manager is responsible for overseeing a significantly larger program without the same managerial support positions, the salary offered is 17.7% lower than that of APS as

[23] We reached out to other bifurcated states but we were unable to obtain the necessary information to compare EPS funding and staffing levels with the programs in those states.
[24] Budgeted funding includes recurring funding such as allocations from the state general fund or federal funds provided in relation to the Older Americans Act. Temporary funding which was received through the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA) and American Rescue Plan Act (ARPA) are not considered by EPS to be budgeted funding as these funds were related to COVID-19 relief and involve deadlines for spending or returning unused funds.

of May 2023. According to GOEA, it is unable to increase the program manager salary because of State Civil Service limitations. While GOEA was able to increase salaries for caseworkers to be more comparable to APS and DCFS caseworkers, increasing salary for management is more challenging because GOEA lacks the administrative structure that enabled LDH to secure additional funding for its APS management. In other words, because EPS does not have the funding to hire the additional staff it needs, its current staff must manage a higher workload at a lower compensation. Insufficient staffing has contributed to many of the issues identified and described throughout this report.

GOEA has struggled to obtain adequate funding to maintain sufficient staffing levels. According to GOEA, it received an additional $4.4 million in federal funding[25] for EPS in fiscal years 2021 and 2022 due to increased funding packages associated with COVID relief. However, approximately $600,000, or 13.6%, of this funding will go to OTS to replace EPS' antiquated data system, and approximately $1.9 million, or 43.2%, will go toward trainings, media campaigns, and technological advancements that will benefit both EPS and APS.[26] GOEA was able to designate approximately $1.1 million (25.0%) of the remaining funding to create six positions, but the positions must be considered temporary because these one-time funds are federally required to be spent by September 2024. According to GOEA, it is challenging to fill temporary positions given the lack of job security offered to candidates. While EPS expects to receive a new source of permanent federal funding through ACL beginning in federal fiscal year 2024, it is unknown as of May 2023 how much funding would be provided. In addition, while GOEA has sought federal funding to supplement its budget, available funding typically involves match requirements[27] that GOEA has been unable to meet.

As a result of insufficient staffing, EPS caseworkers had an average monthly caseload of 85.6 cases during fiscal years 2018 through 2022, which is higher than those of at least 36 other states. According to NAPSA, effective caseload management is essential as the wellbeing and lives of victims depend on prompt and effective adult protective response and can help prevent caseworker burnout.[28] According to the 2012 study conducted by NAPSA and NASUAD, at least 36 states had average adult protection caseloads of no more than 50 cases per caseworker. However, we calculated that EPS caseworkers carried an average of 85.6 cases each month during fiscal years 2018 through 2022.

EPS has not developed a formal caseload standard policy, as recommended by NAPSA. According to EPS, it would like to mirror the average caseloads of most other states with fewer than 50 open cases per caseworker at any given time and no more than 120 cases annually. However, EPS estimates that it would need to

[25] These funds were provided through CRRSA and ARPA, which were passed in response to the COVID-19 pandemic.
[26] According to EPS, the sharing of this funding with APS was encouraged by ACL.
[27] Match requirements refer to a specified percentage of funding that an organization must contribute before it can receive grant funding.
[28] http://www.napsa-now.org/wp-content/uploads/2014/11/TA-Brief-Caseload-Management-FINAL.pdf

hire 15 additional staff to meet this goal. As of May 2023, EPS stated that current staff have annual caseloads that are as high as 253 and continues to worry that it will lose valuable staff due to burnout. EPS policy states that it tries to balance case assignments and considerations are made to prevent large discrepancies in caseloads amongst caseworkers. Specifically, EPS policy requires that new cases are assigned to the caseworker with the fewest assignments during the previous 30-day period in a given region.

EPS' current data system does not allow GOEA to effectively monitor for program compliance and performance. While GOEA has been working with OTS to develop a new system, implementation is delayed and it is unclear whether the new system will meet all of EPS' needs. According to OTS and GOEA, the new system is designed to improve documentation and monitoring capabilities. EPSM currently lacks dedicated fields for certain key data such as risk assessment[29] scores, making it impossible for management to analyze trends in the overall improvement of clients who receive EPS services. The current system is also limited in the case search abilities and types of reports that can be run to assist in program monitoring. To determine whether a report involves a repeat client or perpetrator, intake staff can only search reports by first and last name, which limits the accuracy of search results. According to OTS, the new system will track risk assessment scores and allow users to search by additional identifying information such as address and social security number.

Another limitation is that staff can only run EPSM reports on cases by abuse type, substantiation status, and referral separately. This prevents EPS management from running reports using a combination of these factors to determine if cases were referred as required, such as whether all substantiated cases of financial exploitation were forwarded for legal investigation. Further, current reporting results are limited to counts rather than identifying the associated cases, and none of the reports can be downloaded to analytic software applications such as Excel for in-depth analysis. This prevents EPS from conducting high-level monitoring activities without conducting time-consuming file reviews of a sample of cases. While OTS stated that the new system will have improved reporting capabilities including a report to identify potential repeat cases, it is unclear what type of filters can be applied to reports and whether there will be an option to identify cases associated with each report. According to OTS, the ability to download reports to analytic software applications was not a planned feature for the new system, despite expressing commitment to ensuring that the new system addresses the needs of EPS.

As of May 2023, it is unclear when the upgraded EPSM will be fully available for use by EPS. According to OTS, the new system was initially projected to be ready by September of 2022 when EPS' federal funding was set to expire. However, OTS extended the estimated project completion date to March

[29] EPS uses a risk assessment matrix to rank the client's risk of harm. These scores are calculated at the beginning and end of investigations and are used to determine whether the risk of harm has decreased over the investigation.

2023 due to staffing issues, and EPS obtained federal approval to extend the funding to no later than September 2023. In April 2023, OTS again pushed the completion date to September 2023 citing a discovery that its previous projection did not account for all required system features. While OTS has clarified that EPS will not be responsible for any costs that exceed the amount quoted for the scope of the project, it is unclear which party will be responsible for costs if the timeline exceeds the limitations of EPS' federal funding. According to EPS, if OTS does not complete the upgrade as promised by September 2023, EPS will have to return the federal funding and GOEA cannot afford to pay OTS out of its budget. In addition, the delays in progress have created challenges for EPS in testing modules and training staff on the new system as planned.

To fully use the improved reporting capabilities of EPSM, EPS needs to ensure the information that needs to be captured in monitoring reports is appropriately documented. One advantage of systems that are capable of data analytics is that management can quickly and easily monitor staff performance at a high level by running system reports instead of manually reviewing files. While improvements in analytical capabilities are expected with the new system, EPS needs to ensure that staff are documenting accurate information in the appropriate fields so that it can take advantage of the improved monitoring functionality of EPSM. As mentioned previously, we found closed cases with inaccurate or missing information, as well as cases where information may have been documented but not in the appropriate location. For example, we found cases where case referrals and pre-and post-risk assessment scores were not documented in designated fields. Although supervisors would still be able to find this information when performing case closure reviews, if the information is not documented in the designated fields, it will not be included on monitoring reports run by the new system. As a result, management will not be able to run accurate and complete reports that easily let them determine if all required cases were referred or measure improvements in client risk.

Recommendation 17: GOEA should continue to seek adequate funding for EPS so that it can increase staffing levels as necessary to provide elder protective services.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will continue to seek additional funding to increase staffing levels as necessary. See Appendix A for GOEA's full response.

Recommendation 18: EPS should develop a reasonable caseload standard in policy as recommended by best practices.

Summary of Management's Response: GOEA agreed with this recommendation and stated that it will add the caseload standard of 120 cases per specialist per year to its policy. However, GOEA stated that it will not adopt this standard as a mandatory requirement because a lack of

funding prevents it from hiring additional staff needed to meet the requirement at this time. See Appendix A for GOEA's full response.

Recommendation 19: GOEA should continue to work with OTS to ensure that EPS' new data system includes necessary features to assist in program monitoring.

Summary of Management's Response: GOEA agreed with this recommendation. See Appendix A for GOEA's full response.

Recommendation 20: GOEA should ensure that information that needs to be captured in monitoring reports is appropriately documented in EPSM so that management can generate accurate reports used to monitor the program.

Summary of Management's Response: GOEA agreed with this recommendation and stated that these needs are being implemented in the new data system. See Appendix A for GOEA's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

State of Louisiana
OFFICE OF THE GOVERNOR
Office of Elderly Affairs

John Bel Edwards
Governor

June 21, 2023

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O. Box 94397
Baton Rouge, La 70804-9397

Dear Mr. Waguespack:

Thank you for the opportunity to respond to the Louisiana Legislative Auditor's Performance audit of the Elderly Protective Services Program. We appreciate the hard work and professionalism displayed by your team.
In July 2017, the Elderly Protective Services Program was transferred back to the Governor's Office of Elderly Affairs from the Louisiana Department of Health. Since that time, we have worked to continue services to the elderly population and enhance the performance of the program. As stated in your report, in 2020 we experienced the COVID-19 Pandemic which affected service delivery across the state and caused EPS to have a back log of cases. Additionally EPS continues to experience a shortage in adequate staffing due to budget constraints. We have also experienced limited application pools. We are continuing to make improvements and will utilize recommendations in this report to further enhance the services provided. Below you will find responses to each recommendation.

Recommendation 1: GOEA should continue to seek additional funding to fund staff positions necessary for 24-hour report intake.

GOEA agrees with Recommendation 1 and will continue to seek additional funding in order to fund a 24 hour report line. We recognize this is considered best practices on a national level however we are not able to provide this service due to budget constraints.

Recommendation 2: GOEA should expand its reporting methods by dedicating and advertising a general EPS email address for filing reports of suspected elder abuse, while continuing to develop and implement an online reporting option.

GOEA does not agree with recommendation 2. In establishing an open email for reporting, the agency could potentially be exposed to some liability. We're not able to monitor the information being reported. In many instances it is very difficult to make contact with individuals via email in order to authenticate the information reported.

Recommendation 3: GOEA should track the number of calls the EPS hotline receives, including calls received after hours, so that it can appropriately staff the hotline.

GOEA agrees with Recommendation 3 and will begin tracking the number of calls received on the EPS hotline. It is important to note that GOEA does not have the ability to track calls that are not answered or calls where no voicemail is left.

Recommendation 4: GOEA should advertise the Louisiana Relay service on its website to ensure that EPS reporting is accessible for all individuals, including those who are hearing-impaired or do not speak fluent English.

GOEA agrees with Recommendation 4 and will implement this recommendation.

Recommendation 5: GOEA should formally establish eligibility criteria for certain cases, including those involving financial exploitation, homeless clients, and unnamed clients residing in a known location, and ensure eligibility determinations for these cases are made consistently and appropriately.

GOEA agrees with Recommendation 5 and will begin working to update the policy.

Recommendation 6: GOEA should ensure that all rejected cases are reviewed and require that these reviews be documented.

GOEA agrees with Recommendation 6 and will explore options to make adjustments in the Intake Department in order to designate one staff person to review all rejected cases.

Recommendation 7: GOEA should ensure that rejected cases are referred to other entities when necessary in accordance with policy.

GOEA agrees with Recommendation 7. We will continue to monitor rejected cases to ensure those cases are referred appropriately. GOEA will explore options to make adjustments in the Intake Department in order to designate one staff person to review all rejected cases.

Recommendation 8: EPS should formalize its policies on response priority escalation and ensure they include sufficient details and examples to guide response priority determinations.

GOEA agrees with Recommendation 8 and will begin working to update the policy.

Recommendation 9: EPS should provide training to staff on response priority policies and help ensure that they assign response priorities that comply with policy and are consistent.

GOEA agrees with Recommendation 9 and will provide additional training.

Recommendation 10: EPS should provide training to intake staff on identifying situations that warrant emergency medical services and ensure that intake staff report medical emergencies when necessary.

GOEA agrees with Recommendation 10 and will provide additional training.

Recommendation 11: EPS should ensure that staff comply with timeline requirements for assigning cases, contacting clients, documenting case activity and closing cases.

GOEA agrees with Recommendation 11 and will provide additional training.

Recommendation 12: GOEA should ensure that supervisors perform and document supervisory case reviews for all cases prior to case closure as required by policy.

GOEA agrees with Recommendation 12 and will provide additional training.

Recommendation 13: GOEA should develop a standardized tool to guide supervisors during case reviews to help ensure that they identify all missing or inaccurate case information.

GOEA agrees with Recommendation 13 and will provide additional training. The new system will include system checks prior to case closure to ensure all required fields are completed.

Recommendation 14: EPS should formally establish policies detailing investigation procedures such as coroner notifications, obtaining cause of death, and referring cases to law enforcement when clients die during investigations of physical abuse or neglect.

GOEA agrees with Recommendation 14 and will begin working to update the policy.

Recommendation 15: EPS should ensure that caseworkers are developing and documenting service plans for all cases that address all issues identified, as required by policy.

GOEA agrees with Recommendation 16 and will provide additional training.

Recommendation 16: EPS should ensure that caseworkers follow up on all service plans prior to closing cases to ensure that clients receive services as planned, as required by policy.

GOEA agrees with Recommendation 16 and will provide additional training.

Recommendation 17: GOEA should continue to seek adequate funding for EPS so that it can increase staffing levels as necessary to provide elder protective services.

GOEA agrees with Recommendation 17 and will continue to seek additional funding in order to increase staffing levels as necessary.

Recommendation 18: EPS should develop a reasonable caseload standard in policy as recommended by best practices.

GOEA agrees with Recommendation 18. GOEA will add the caseload standard of 120 cases per specialist per year to our policy, however, we will not adopt this standard as a mandatory requirement. At this time a lack of funding prevents GOEA from hiring additional staff needed to meet the requirement.

Recommendation 19: GOEA should continue to work with OTS to ensure that EPS's new data system includes necessary features to assist in program monitoring.

GOEA agrees with Recommendation 19 and will continue working with OTS to ensure the new data system includes necessary features to assist in program monitoring.

Recommendation 20: GOEA should ensure that information that needs to be captured in monitoring reports is appropriately documented in EPSM so that management can generate accurate reports used to monitor the program.

GOEA agrees with Recommendation 20 and these needs are being implemented in the new data system.

If there are questions, concerns or additional requirements necessary to the responses to this audit, please contact Ebony Phillips, Elderly Protective Services Program Manager, at ebony.phillips2@la.gov or 225-342-7292.

Sincerely,

Shirley L Merrick,
Executive Director

Post Office Box 61 * Baton Rouge, Louisiana 70821 * Phone 225-342-7100 * Fax 225-342-7133 * www.goea.louisiana.gov

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our performance audit of the Governor's Office of Elderly Affairs' (GOEA) oversight of Elderly Protective Services (EPS). We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit covered July 1, 2017 through June 30,2022. Our audit objective was:

To evaluate GOEA's oversight of cases of elder abuse and neglect in its EPS program.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

We obtained an understanding of internal control that is significant to the audit objective and assessed the design and implementation of such internal control to the extent necessary to address our audit objective. We also obtained an understanding of legal provisions that are significant within the context of the audit objective, and we assessed the risk that illegal acts, including fraud, and violations of applicable contract, grant agreement, or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

To answer our objective, we performed the following audit steps:

- Researched relevant state laws, regulations, policies, and best practices related to protective services.
- Researched other relevant information such as GOEA's Annual Reports.
- Met with stakeholder groups to understand any current concerns.
- Met with GOEA management and staff to obtain an understanding of activities performed by EPS to protect clients from elder abuse and neglect.
- Obtained and analyzed EPS' Elderly Protection Services Management System (EPSM) data for fiscal years 2018 through 2022. This data included reports of elder abuse and neglect received by EPS as well as determinations and activities by EPS staff to screen, investigate, and

close cases. We used this data to calculate general statistics on cases and perform in-depth file reviews.

- Identified a targeted selection[30] of 100 cases from each year during fiscal years 2018 through 2022, as well as 156 additional files that were identified during general data analysis,[31] and reviewed applicable[32] files within this selection to determine whether cases were screened, assigned, investigated, reviewed, and closed in accordance with policy. Specifically, we reviewed the following:
  - 30 rejected cases and compared the determinations to EPS policy
  - 71 rejected cases that met referral criteria[33] to determine if the cases were referred
  - 92 accepted cases to determine whether EPS assigned cases and contacted clients within the timeframes established by policy
  - 77 closed cases to evaluate any gaps in case activity and determine the prevalence of client deaths during case inactivity
  - 142 closed cases to determine whether supervisory reviews were performed prior to closure
  - 58 cases that met criteria for required service plans to determine whether a formal service plan was developed to address each problem as required by policy
  - 54 cases that had at least partially developed service plans to determine whether EPS followed up to ensure completion of the service plans
  - 21 abuse and neglect cases involving client death to determine whether EPS notified coroners or documented official causes of death
- Note that cases may have been reviewed in multiple file reviews with differing sample sizes. Due to time constraints, we reviewed fewer files

[30] Files were reviewed based on targeted selection and not statistical sampling; therefore, resulting information should not be generalized across all EPS cases.
[31] For example, cases that were closed without a disposition and cases that were accepted but were not assigned to an existing EPS region.
[32] We further filtered cases from the initial selection to evaluate compliance with certain policies. For example, to evaluate compliance with case rejection policies, we filtered to include cases that were rejected by EPS.
[33] These cases were rejected due to reasons such as ineligibility due to the client's age or allegations beyond the scope of EPS services but were subject to policies related to the referrals of rejected cases to appropriate entities.

when the reviews required a greater depth of analysis, and therefore more time. For example, when evaluating case inactivity, we reviewed fewer closed cases because it required complex reviews of historical case notes and entry dates. In contrast, we were able to review more closed cases when determining whether supervisory reviews were performed prior to closure because it only required the detection of a single review note located at the end of each case log.

- Communicated additional EPS recommendations to GOEA via non-public letter.