Information Memorandum Transmittal
Developmental Disabilities Services

Oregon Department of Human Services

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Topic: Developmental Disabilities

Due date:

Subject: Statewide Incident Management Analysis, January-March 2022

Applies to (*check all that apply*):

- ☐ All ODHS Employees
- ☐ Area Agencies on Aging: {Select type}
- ☐ Aging and People with Disabilities
- ☐ Self Sufficiency Programs
- ☒ County DD Program Managers
- ☒ Support Service Brokerage Directors
- ☒ ODDS Children's Residential Services
- ☐ Child Welfare Programs
- ☐ County Mental Health Directors
- ☐ Health Services
- ☒ Office of Developmental Disabilities Services (ODDS)
- ☒ ODDS Children's Intensive In Home Services
- ☒ Stabilization and Crisis Unit (SACU)
- ☒ Other (*please specify*): Partners and Providers of ODDS

Message:
ODDS has been conducting the same Serious Incident (SI) analysis required of each Case Management Entity (CME) for the CAM (Centralized Abuse Management) system. These analyses are completed by the ODDS Quality Improvement team with the intent of identifying and monitoring trends. This report covers January – March of 2022.

Communication/training:
This transmittal will be discussed during the next Monthly Transmittal Review. Please send questions in advance to ODDS.Questions@dhsoha.state.or.us.

The Monthly Transmittal Reviews are held the second Wednesday of every month at 2 pm using the Zoom platform. Please register in advance for these meetings: https://www.zoomgov.com/meeting/register/vJIsc-qvqD8iGURx5OQk8TAdlS6Arg9ZAf4

After registering, you will receive a confirmation email containing an appointment and information about joining the meeting. American Sign Language (ASL) and live captioning will be provided. To request other accommodations or languages, please send an email to ODDS.Questions@dhsoha.state.or.us at least three business days prior to the meeting.

If you have any questions about this information, contact:

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Statewide Incident Management Analysis

January – March 2022

ODDS Serious Incidents
January-March 2022

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Introduction

All Case Management Entities (CMEs) are required by OAR 411-415-0055 to form an incident management team to review serious incidents[1] for evidence of trends. DD-PT-22-046 explains how to adhere this this rule. CMEs are further required, by rule and by contract, to submit findings to the Department quarterly.

ODDS has completed a review of all serious incidents that occurred during January, February, and March 2022, the findings are available in this report.

CMEs are not compared to each other, nor to statewide data and trends. ODDS is interested in understanding how each CME is working to minimize or mitigate the negative impact of serious incidents and demonstrate follow-up to prevent reoccurrence of serious incidents.

[1] CMEs are required to report on abuse trends as well. The Office of Training, Investigations and Safety (OTIS) tracks abuse reporting and therefore ODDS has not included abuse numbers in this report.

Diversity, Equity, and Inclusion

ODDS acknowledges the importance of analyzing how diverse communities are impacted by serious incidents. The equity information available in Centralized Abuse Management system (CAM) is limited and therefore correlations currently cannot be analyzed.

Entering diversity and equity data into CAM is not a current rule requirement. When complete data is not entered on the aspects of an individual's identity, it is difficult to adequately understand the impacts of serious incidents and abuse on diverse populations. The intersectionality of an Individual’s identity may add additional complexity due to possible bias and discrimination.

Case Management Entities are encouraged to learn more about how to discuss diversity, equity, and inclusion here: https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

Supporting people where they are means knowing who they are. The system can only know who the individuals served are when CMEs ensure demographic data regarding diversity is entered in the CAM.

Trauma Responsivity

The Incident Management Team meetings and the review of serious incidents need to be handled with sensitivity. Occasionally, staff may experience feelings or memories when talking about serious incidents and abuse. This indirect exposure to trauma through the retelling of traumatic events is commonly referred to as secondary trauma, compassion fatigue, or vicarious traumatization. The act of listening to trauma stories comes with an emotional toll that may affect physical health and emotional wellbeing. There is potential for this to be reflected in the workplace. Individual and supervisory awareness of the effects of this indirect trauma exposure is a basic part of protecting the health and longevity of staff and ensure individuals served receive the best possible support.

Trauma Informed Oregon is a collaboration of university, public and private partners, individuals with lived experience, youth and family members committed to creating and sustaining a trauma informed system of care in Oregon. www.TraumaInformedOregon.org

Serious Incident Entry Data

Serious Incidents (SIs)[2] opened: 3,445[3]

- Previous reporting period: 3,125
- This is an increase from the previous period.
- To what is this trend attributed:
    - 1,702 serious incidents opened between January 2022 and March 2022 were identified as having no paid provider at time of incident.
    - 2,201 Individuals experienced between one and 31 serious incidents.
        - Individuals experienced an average of 2 serious incidents.
        - 1,878 Individuals experienced one or two serious incidents.
        - 318 Individuals experienced between three and 15 serious incidents.
        - 3 Individuals experienced more than 15 serious incidents.
- Actions: Notify the Case Management Entities (CMEs) who support the Individuals who experienced more than 15 serious incidents to ensure they are aware, have plans, and are monitoring.

SIs Closed: 3,142

- Previous reporting period: 3,001
- This is not a statistically significant[4] change from the previous period.

SIs entered late[5]: 623 - 18% of all SIs

- Previous reporting period: 405
- This is an increase from the previous period.
- 623 serious incidents were entered outside of rule requirements. SIs were entered between one and 452 days late, with an average of 35 days late. 53 SIs were entered more than 100 days late.

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[2] OAR 411-415-0055(1)(a) All reports of abuse and serious incidents must be entered into CAM regardless of the date of the incident.

[3] A visual representation of all serious incident entries can be found in Appendix B

[4] Given the available data, no inferences can be made. The difference between the two quarters may be as the result of chance or circumstances.

[5] OAR 411-415-0055(1)(b) A serious incident must be entered into CAM within seven calendar days of the CME becoming aware that a serious incident has occurred.

Total SIs entered late	623
Average days late	452
Number below average	464
Number above average	159
Entered 100+days late	53

- To what is this trend attributed: No definitive determination can be made to indicate why there is an increase in serious incidents being entered late, the increase may be influenced by a change between CMEs.
    - Community Developmental Disabilities Programs (CDDPs) entered a total of 2,583 SIs. 2496 of these SIs were entered beyond the timelines identified in rule. On average, 19.2% of CDDP SI entries were entered late.
  - Brokerages entered a total of 938 SIs. 99 of these SIs were entered beyond the timelines identified in rule. On average, 10.6% of Brokerage SI entries were entered late.
  - CMEs entered between 80% and 0% of their serious incidents late.
    - 18 CMEs entered fewer than 10% of their serious incidents beyond the timeline identified in rule.
    - 19 CMEs entered between 11% and 35% of their serious incidents beyond the timeline identified in rule.
    - 5 CMEs entered more than 35% their serious incidents beyond the timeline identified in rule.
- Actions: Notify the CMEs who had serious incidents entered more than 100 days late to ensure they are aware and have plans in place to address the late entries.

SIs not closed within 30 days of CME entry[6]: 502 – 15% of all SIs

- Previous reporting period: 444
- This is an increase from the previous period.
  - 502 serious incidents were closed outside of rule requirements. SIs were closed between one and 446 days late, with an average of 46 days late. 47 SIs were closed more than 100 days late.

Total SIs closed late	502
Average days late	53
Number below average	455
Number above average	162
Closed 100+ days late	47

  - To what is this trend attributed: CMEs may be waiting on information to close SI entries. ODDS will be exploring the reasons documented within CAM when the SI entry is closed late.
    - CDDPs entered a total of 2,583 SIs. 400 of these SIs were closed beyond the timelines identified in rule. On average, 15.5% of CDDP SI entries were entered late.
    - Brokerages entered a total of 938 SIs. 87 of these SIs were entered beyond the timelines identified in rule. On average, 9.3% of Brokerage SI entries were entered late.
    - CMEs closed between 62% and 0% of their serious incidents late.
      - 23 CMEs closed fewer than 10% of their serious incidents beyond the timeline identified in rule.
      - 14 CMEs entered between 11% and 30% of their serious incidents beyond the timeline identified in rule.
      - 5 CMEs entered more than 34% their serious incidents beyond the timeline identified in rule.
- Actions: Notify the CMEs who had serious incidents closed more than 100 days later than outlined in rule to ensure they are aware and have plans in place to address the late closures.

[6] OAR 411-415-0055(1)(d) Every serious incident entered into CAM must be closed in CAM no more than 30 calendar days from the date the incident was entered into CAM.

SIs entered with "No Recommended Actions": 1,328– 38% of all SIs

- Previous reporting period: 1,421
- This is not a statistically significant change from the previous period. CMS requires an incident management system is in place and effectively resolves identified incidents and preventing further similar incidents to the extent possible. The goal of follow-up activities or recommended actions is to prevent reoccurrence of serious incidents and to mitigate the negative impact of these incidents. Outside of CAM there is no statewide consistently measurable way to identify these follow-up actions. Using the "Recommended Actions" field object within CAM provides a statewide measurement that can be trended.
- This trend may be attributed to recommended actions not required by rule. CMEs may be using a separate process to track follow-up activities.
- Actions: Notify the CMEs who had more than 40% of their serious incidents entered with no recommended action to ensure they are aware and the serious incidents have alternate follow up plans in place.

Serious Incident Types[7]

Emergency Medical Care[8]: 2,643 – 77% of all SI types

- Previous reporting period: 2,303
- This is an increase from the previous period.
- This trend may be attributed to:
    - 2,643 serious incidents reports were created for emergency medical care
    - 1,785 Individuals experienced between one and 31 emergency medical care incidents.
        - Individuals experienced an average of 1 serious incident for emergency medical care.
        - 1,340 Individuals experienced one serious incident for emergency medical care.
        - 162 Individuals experienced between three and nine serious incidents for emergency medical care.
        - 6 Individuals experienced between ten and thirteen serious incidents for emergency medical care.
        - 3 Individuals experienced more than fourteen serious incidents for emergency medical care.
- Actions: Notify the CMEs who support the Individuals who experienced more than 14 serious incidents for emergency medical care to ensure they are aware, have plans, and are monitoring.

Unplanned Hospitalization: 506– 15% of all SIs

- Previous reporting period: 372
- This is an increase from the previous period.
- This trend may be attributed to:
    - 506 serious incidents reports were created for unplanned hospitalization.

[7] OAR 411-317(199)

[8] OAR 411-317(77) "Emergency Medical Care": (a) Means an individual receives care from any of the following: (A) An urgent care center. (B) Emergency room. (C) Emergency medical technicians regardless of whether the individual is transported. (D) A psychiatric intervention team regardless of whether the individual is transported. (E) Care delivered in a physician's office that is typically received in an emergency room or urgent care center. (b) Emergency medical care does not include medical care by a paid provider or routine physical health care at an urgent care center or emergency room.

    - 429 Individuals experienced between one and 5 serious incidents for unplanned hospitalization.
        - Individuals experienced an average of 1 serious incidents for unplanned hospitalization.
        - 51 Individuals experienced between two and three serious incidents for unplanned hospitalization.
        - 4 Individuals experienced between four and five serious incidents for unplanned hospitalization.
- Actions: Notify the CMEs who support the Individuals who experienced more than 4 serious incidents unplanned hospitalization to ensure they are aware, have plans, and are monitoring

Act of Physical Aggression[9]: 274 – 8% of all SIs

- Previous reporting period: 303
- This is not a statistically significant change from the previous period.
- This trend may be attributed to:
    - 274 serious incidents reports were created for acts of physical aggression resulting in injury.
    - 168 Individuals experienced between one and 10 serious incidents for acts of physical aggression.
        - Individuals experienced an average of 2 serious incidents for acts of physical aggression.
        - 148 Individuals experienced one or two serious incidents for acts of physical aggression.
        - 12 Individuals experienced between three and five serious incidents for acts of physical aggression.
        - 8 Individuals experienced more than 5 serious incidents for acts of physical aggression.
- Actions: Notify the CMEs who support the Individuals who experienced more than 5 serious incidents for acts of physical aggression to ensure they are aware, have plans, and are monitoring.

Death: 84 – 2% of all SIs

- Previous reporting period: 89.

[9] OAR 411-317(162) "Physical Aggression" means an intentional action taken by an individual meant to harm another person that results in injury, including to the individual.

- This is not a statistically significant change from the previous period.
- This trend may be attributed to:
    - Multiple serious incidents records were created for one Individual's death.
- Actions: The Quality Management Data Analyst will reach out to the appropriate end user to assist with the correction for the multiple incidents for a single death.

Missing Person[10]: 75 – 2% of all SIs

- Previous reporting period: 107
- This is a decrease from the previous period.
- This trend may be attributed to:
    - 75 serious incidents reports were created due to a person missing beyond the time frame established in their ISP.
    - 49 Individuals experienced between one and 17 serious incidents due to being missing beyond the time frame established in their ISP.
        - Individuals experienced an average of 2 serious incidents due to being missing beyond the time frame established in their ISP.
        - 48 Individuals experienced between one and five serious incidents due to being missing beyond the time frame established in their ISP.
        - 1 Individual experienced 17 serious incidents due to being missing beyond the time frame established in their ISP.
- Actions: Notify the CMEs who support the Individuals who experienced more than 5 serious incidents due to a person missing beyond the timeline established in the Individual's ISP to ensure they are aware, have plans, and are monitoring.

Psychiatric Hospitalization: 73 – 2% of all SIs

- Previous reporting period: 60
- This is an increase from the previous period.
- This trend may be attributed to:

[10] OAR 411-317(199) (e) An individual is missing beyond the time frame established in their ISP.

    - 73 serious incidents reports were created for psychiatric hospitalization.
    - 61 Individuals experienced between one and three serious incidents for psychiatric hospitalization.
        - 50 Individuals experienced one serious incident for psychiatric hospitalization.
        - 10 Individuals experienced two serious incidents for psychiatric hospitalization.
        - 1 Individual experienced more than three serious incidents for psychiatric hospitalization.
- Actions: Notify the CMEs who support the Individuals who experienced more than two serious incidents for psychiatric hospitalization to ensure they are aware, have plans, and are monitoring.

Medication Errors[11] with Adverse Consequences[12]: 26 – 1% of all SIs

- Previous reporting period: 21
- This is not a statistically significant change from the previous period.
- This trend may be attributed to:
    - 26 serious incidents were created for a Medication Error.
    - 25 Individuals experienced one medication error. One Individual experienced two medication errors.
- Actions: Notify the CMEs who support the Individuals who experienced more than 1 serious incident for medication errors to ensure they are aware, have plans, and are monitoring

Suicide Attempt: 31 – 1% of all SIs

- Previous reporting period: 21.
- This is an increase from the previous period.
- This trend may be attributed to:
    - 31 serious incidents reports were created for suicide attempt.

[11] OAR 411-317 (135) "Medication Error" means the following: (a) A medication to address a condition or illness that, if the condition or illness is left untreated may likely result in hospitalization or bodily injury, was: (A) Taken in the wrong dosage; or (B) Administered by the wrong route; or (C) Not given. (b) A medication was given to a person for whom it was not prescribed.

[12] OAR 411-317 (136) "Medication Error with Adverse Consequences" means any medication error that results in direct harm or jeopardizes an individual's health and safety resulting in emergency treatment or a required call to the prescriber.

        - 22 Individuals experienced one serious incident for suicide attempt.
        - 3 Individuals experienced two serious incidents for suicide attempt.
        - 1 Individual experienced three serious incidents for suicide attempt.
- Actions: Notify the CMEs who support the Individuals who experienced more than one serious incident for suicide attempt to ensure they are aware, have plans, and are monitoring.

Safeguarding Interventions[13] resulting in an injury: 16 – >1% of all SIs

- Previous reporting period: 16
- This is the same as the previous period.
- This trend may be attributed to:
    - 16 serious incidents reports were created for safeguarding interventions resulting in an injury.
    - 13 Individuals experienced between one and 3 serious incidents for safeguarding interventions resulting in an injury.
        - 12 Individuals experienced between one and two serious incidents for safeguarding interventions resulting in an injury.
        - 1 Individuals experienced three serious incidents for safeguarding interventions resulting in an injury.
- Actions: Notify the CMEs who support the Individuals who experienced more than two serious incidents as a result of a safeguarding intervention resulting in an injury to ensure they are aware, have plans, and are monitoring.

Emergency Physical Restraint[14]: 27 – >1% of all SIs

- Previous reporting period: 40

[13] OAR 411-317 (192) "Safeguarding Intervention" means a manual physical restraint, applied by a designated person certified to use the safeguarding intervention according to OAR 411-304-0160, that: (a) Has been authored by a behavior professional as an emergency crisis strategy within a Positive Behavior Support Plan; (b) Has been consented to through the individually-based limitation process consistent with OAR 411-415-0070; and (c) Is used as an emergency crisis strategy to protect an individual from: (A) Harming themselves; (B) Harming others; or (C) When the individual's behavior is likely to lead to intervention by law enforcement.

[14] OAR 411-317 (78) "Emergency Physical Restraint" means a manual physical restraint that is: (a) Part of an ODDS approved behavior intervention curriculum. (b) Delivered by a designated person trained to deliver the

- This is a decrease from the previous period.
- This trend may be attributed to:
    - 27 serious incidents reports were created for emergency physical restraint.
    - 16 Individuals experienced between one and 10 serious incidents for emergency physical restraint.
        - 13 Individuals experienced between one serious incident for emergency physical restraint.
        - 2 Individuals experienced two serious incidents for emergency physical restraint.
        - 1 Individual experienced 10 serious incidents for emergency physical restraint.
- Actions: Notify the CMEs who support the Individuals who experienced more than two serious incidents for emergency physical restraint to ensure they are aware, have plans, and are monitoring.

Interventions that contain restraint:

- There were 181 Individuals where a serious incident record was created for physical aggression that resulted in an injury, or a safeguarding intervention that resulted in an injury, or an emergency physical restraint.
- This trend may be attributed to:
    - 162 Individuals experienced between one and three serious incidents for interventions that contain restraint.
    - 14 Individuals experienced between three and six serious incidents for interventions that contain restraint.
    - 5 Individuals experienced more than six serious incidents for interventions that contain restraint.
- Actions: Notify the CMEs who support the Individuals who experienced more than six serious incidents for interventions that contain restraint to ensure they are aware, have plans, and are monitoring.

intervention. (c) Not a safeguarding intervention. (d) Not included in a Positive Behavior Support Plan or not agreed to in an individually based limitation.

No Provider at The Time of Incident

There were 3,445 serious incidents entries in CAM between January and March 2022. Of these, 1,702 serious incident entries indicated there was no provider of record at the time of the incident. Approximately 49% of the serious incidents reported between January and March 2022 occurred when there was no provider identified at the time of the incident.

1,175 Individuals experienced between one and thirty-one serious incidents were marked in CAM as having no paid provider at the time of the serious incident.

- 1,159 Individuals experiencing between one and five serious incidents were marked in CAM as having no paid provider at the time of the serious incident.
- 12 Individuals experiencing between six and eleven serious incidents were marked in CAM as having no paid provider at the time of the serious incident.
- 4 Individuals experiencing more than 11 serious incidents were marked in CAM as having no paid provider at the time of the serious incident.

- Actions: Notify the CMEs who support the Individuals experiencing more than eleven serious incidents where no provider was on record at the time of the incident to ensure they are aware, have plans, and are monitoring.

Appendix A: Individuals Supported – by CME

Case Management Entity	Individuals Supported
Baker - New Directions Northwest	78
Benton	566
CIIS	383
Clackamas	2321
Clatsop	243
Columbia	354
Community Counseling Solutions – Gilliam, Grant, Lake, Morrow, Wheeler	95
Community Living Case Management – Coos, Curry, Douglas, Hood River, Josephine, Sherman, Wasco	1940
Community Pathways Inc	488
Connections Case Mgmt.	675
Creative Supports Inc	521
Crook - Best Care	81
Deschutes	787
EOSSB	472
Full Access	492
Full Access High Desert	385
Harney - Symmetry Care	30
Inclusion Inc	657
INW - Independence Northwest	518
ISN - Integrated Service Network	532
Jackson	1213
Jefferson - Best Care	70
Klamath	524
Lane	3022
Lincoln	268
Linn	962
Malheur - Lifeways	153
Marion	2450
Multnomah	4877
Polk	663
Resource Connections Mid-Valley	639
Resource Connections South-Valley	531
SDRI - Self Determination Resources Inc	711
State Children's Residential	156
Tillamook	196
UCP	855
Umatilla	336

Case Management Entity	Individuals Supported
Union - Center For Human Development	187
Wallowa Valley Center For Wellness	29
Washington	2540
Yamhill	707
Grand Total	**32707**

Appendix B: Serious Incident entries – by CME

Case Management Entity	Number of Individuals with SI Entries in CAM
Baker - New Directions Northwest	0
Benton	61
CIIS	89
Clackamas	143
Clatsop	5
Columbia	14
Community Counseling Solutions – Gilliam, Grant, Lake, Morrow, Wheeler	16
Community Living Case Management – Coos, Curry, Douglas, Hood River, Josephine, Sherman, Wasco	361
Community Pathways Inc	60
Connections Case Mgmt.	132
Creative Supports Inc	85
Crook - Best Care	10
Deschutes	59
EOSSB	98
Full Access	40
Full Access High Desert	99
Harney - Symmetry Care	2
Inclusion Inc	35
INW - Independence Northwest	52
ISN - Integrated Service Network	69
Jackson	159
Jefferson - Best Care	23
Klamath	89
Lane	113
Lincoln	4
Linn	65
Malheur - Lifeways	0
Marion	174
Multnomah	312
Polk	129
Resource Connections Mid-Valley	80
Resource Connections South-Valley	40
SDRI - Self Determination Resources Inc	63
State Children's Residential	122
Tillamook	39
UCP	33
Umatilla	0
Union - Center For Human Development	25

Statewide Incident Management Analysis

Appendix B: Serious Incident entries – by CME

Case Management Entity	Number of Individuals with SI Entries in CAM
Wallowa Valley Center For Wellness	0
Washington	329
Yamhill	80
	3309