Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

Office of Developmental Disabilities Services
Incident Management Team (IMT) Report
Statewide Review

The Office of Developmental Disabilities Services (ODDS) is completing the statewide review of the Centralized Abuse Management (CAM) Serious Incident (SI) data using the same form Case Management Entities (CMEs) are required to use and report on quarterly. For questions that reference CMEs below, (i.e., "What actions is your CME taking to remediate this?") the response is referencing actions ODDS is taking. ODDS may follow up with specific CMEs if necessary, however this report is focused solely on statewide data and trends. The data reports utilized to compile this report were from February, 2025.

Reporting quarter

Quarter 4 (October 1 - December 31)

Year reviewed

2024

Serious Incident (SI) data

1. Number of SIs entered by the CME **more than 7** days after becoming aware of the incident: 741 (15%)
    - Number of SIs entered by the CME **within 7 days** of becoming aware of the incident: 4,171 (85%)
    - In comparison to last quarter, please state if there is an increase or decrease of late entries for your CME: Increase, there were 741 SIs entered late this quarter, compared to 739 SIs entered late last quarter.
    - Please provide reasoning for the late entries: There are multiple factors that could impact this trend. There was a 4% increase in the total number of SIs entered this quarter, which could account for the higher number of late entries this quarter. Six CMEs accounted for 461 (62%) of the late SI entries this quarter. These CMEs each had 40 or more late SI entries and two of them had over 100 late SI entries.
    - What actions is your CME taking to remediate this, please list: ODDS Quality Improvement (QI)Team will continue to work with ODDS units who support CMEs including the Case Management Supports Services (CMSS) Unit on supporting CMEs with CAM entry practices. QI is working on developing a compliance metric in collaboration with the CMSS unit focused on SI

timelines. This will include identifying CMEs who are not in alignment with the current compliance threshold of 87% and identifying follow up mechanisms from ODDS.

2. Number of SIs **not closed within 30 days** of CME entry: 681 (14%) SIs were not closed within 30 days of entry. Out of these SIs, 159 (3%) SIs indicate an SI Status of "SI in process" at the time this data was pulled.
    - Number of SIs **closed by the CME within 30 days** of CME entry: 4,231 (86%)
    - In comparison to last quarter, please state if there is an increase or decrease of late closures for your CME: Increase, there were 681 SIs closed late this quarter, compared to 529 SIs closed late last quarter.
    - Please provide reasoning for the late closures: There are several factors to consider. This quarter, three CMEs were responsible for 278 (41%) of the late closures. These three CMEs had 90 or more late closures for the quarter. This quarter, 41 SIs were closed late and did not have a CME attached to the record. Each CME is able to implement their own business process to remain in compliance with CAM entry requirements. Several CMEs have informed ODDS that their internal business process contains additional requirements for their specific CME that must be met before an SI can be closed in CAM, which may impact the timeliness of SIs closures.
    - What actions is your CME taking to remediate this, please list: QI will continue to work with ODDS units who support CMEs, including the CMSS Unit on best practices for CAM record maintenance. QI and CMSS have been collaborating with CME partners to identify IMT practices CMEs have implemented. QI is working on developing a compliance metric in collaboration with the CMSS unit focused on SI timelines. This will include identifying CMEs who are not in alignment with the current compliance threshold of 87% and identifying follow up mechanisms from ODDS.
3. Number of SIs entered by the CME **with "No Recommended Action"** selected: 1,605 (33%)
    - Number of SIs entered by the CME with an identified Recommended Action **other than "No Recommended Action"**: 3,205 (67%)
    - In comparison to last quarter, please state if there is an increase or decrease of Recommended Actions being identified by your CME: Increase, there were 2,903 Recommended Actions (RAs) identified last quarter. In reviewing this quarters data, QI observed some discrepancy of total SIs between the CAM reports provided. There is a difference of 102 SIs between the Recommended Action report and the Serious Incident report in CAM. The percentages for

this have been calculated utilizing the total number of Recommended Action records, not the total number of SIs.

- Please provide any actions your CME is taking related to the identification of Recommended Actions in SI entry: ODDS continues to work with CAM Support to ensure report functionality is working correctly. This information will be shared with CMSS unit and internal workgroups. There are multiple options when creating a RA for a CME to indicate what actions or follow-up needs to occur. This includes the option of selecting "No Recommended Action". ODDS continues to encourage CMEs to document any actions or follow-up actions that have occurred or still need to occur related to the SI within the RA record within CAM. ODDS is working with CAM to review report options.

4. Please identify the number of SIs entered for each SI category below:

SI category	Total number submitted **two previous** reporting periods prior	Total number submitted **last** reporting period	Total number entered **this** reporting period	Percentage of total SIs entered **this** quarter
Death	105	74	79	2%
Suicide Attempt	67	58	42	.9%
Act of Physical Aggression	279	263	261	5%
Safeguarding Intervention/Equipment Resulting in Injury	23	18	13	.2%
Emergency Physical Restraint	28	21	32	.6%
Unplanned Hospitalization	607	587	581	12%
Missing Person	94	97	89	2%
Emergency Medical Care	3,673	3,859	4,055	82%
Medication Error with Adverse Consequences	15	28	16	.3%
Psychiatric Hospitalization	105	116	64	1%
Total SIs entered	4,609	4,729	4,912	N/A

5. When reviewing the SI category types reported, please identify the SIs that had **an increase** in this reporting period: The SI categories that experienced an increase this quarter were Death, Emergency Physical Restraint and Emergency Medical Care (EMC).
    - Please describe the patterns your CME is seeing: There was a 4% increase in the total number of SIs entered this quarter. EMC continues to be the top reported SI category. It is important to note that the total SIs listed in the table above reflect all SIs entered in Q4. Each SI can have multiple SI categories associated with the SI record.
    - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QI will share this information with the internal IMT workgroup and the CMSS Unit. The definition for EMC was updated effective October of 2024 to focus on why an individual was seeking medical care instead of where the emergency medical care was provided.
6. When reviewing the SI category types experiencing **an increase** of reporting, are these SIs connected to the **same provider(s) or location(s)**?: ODDS authorizes multiple provider types and several of these provider types can have different site locations. A Medicaid provider agency can be associated with multiple SIs, however these incidents could occur at different site locations. Individuals can also be served through Personal Support Workers (PSWs) across the state who have different reporting requirements. When reviewing these categories, 2,403 SIs (58%) of the SIs entered in these categories for Q4 did not have a responsible provider associated with the SI record.
    - Please describe the patterns your CME is seeing: When looking at the three SI categories that had an increase this quarter it was observed that there were several providers who were associated with multiple SIs in each of these categories. ODDS also observed that CMEs were not indicating responsible providers in all SI entries, leaving “blank” fields in the SI record.
    - Please describe the follow-up actions your CME is taking to prevent reoccurrence: CMEs are responsible for identifying and following up on concerning patterns/trends of SIs in their geographical service area. QI will share this data with the internal ODDS IMT workgroup. QI is recommending that ODDS review data validations for required fields when entering an SI into CAM.
7. When reviewing the SI category types experiencing **an increase** of reporting, are these SIs connected to the **same individual(s)** experiencing frequent incidents? When reviewing the SI categories that had an increase this quarter, across the state there were several individuals with reoccurring SIs.

- Please describe the patterns your CME is seeing: When reviewing the SI categories there are multiple individuals who experienced more than one SI in a specific category. There were also several individuals who experienced multiple SIs in multiple SI categories.
- Please describe the follow-up actions your CME is taking to prevent reoccurrence: CMEs are responsible for identifying and following up on concerning patterns/trends of SIs in their geographical service area. QI will share this data with the internal ODDS IMT workgroup to discuss follow up actions needed.

8. Please share any concerns, successes or identify any patterns your CME has observed this quarter with **providers**: When reviewing the total SIs this quarter ODDS observed that 56% of SIs identified did not list a responsible provider at the time of the incident, six Medicaid Agencies had more than 40 SIs and 267 Medicaid Agencies experienced one SI. ODDS received 42 CME timely IMT reports, and 7 late CME IMT reports this quarter.
    - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QI will continue to work with internal partners who work with CMEs regarding the IMT process and bring identified action items to the appropriate meetings for discussion. QI is recommending ODDS make required field updates in CAM to ensure accurate data is captured.
9. Please share any concerns, successes, or identify any patterns your CME has observed this quarter with **individuals**: CMEs are responsible for the monitoring and oversight for individuals receiving services in their geographical service area. However, in reviewing this data QI did make observations at the statewide level as noted previously in this report. In reviewing this quarter's data, QI observed that 19 individuals across the state experienced more than 10 Serious incidents this quarter. This quarter, there were 4,912 SIs that impacted 3,073 individuals across the state. When looking at Missing Person SIs, there were twelve individuals who experienced more than 1 SI in this category this quarter. Of those, one individual had 11 Missing Person SIs and the other had 18 Missing Person SIs.
    - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QI will share this information with the internal ODDS partners. CMEs are expected to follow up with the individuals they serve regarding reoccurring incidents.

☐ **This CME is a Brokerage and has completed the required components.**

Please submit the completed IMT report to imt.submissions@odhsoha.oregon.gov by the associated due date. Thank you!

Abuse and Death Review (DR) data

10. Number of Death Reviews **entered this quarter**: 77
    - Number of Death Reviews entered **within one business day** after becoming aware of the death: 61 (79%)
    - Number of Death Reviews completed with **the required timelines of 55 days**: At the time of this report, 16 DRs had a status of "DR Final" with no days late attached to the record, 21 DRs had a status of "DR Final" with "DR Days Late" attached to the record. There were 35 DRs with a status of "DR In Process", of these, 19 did not have "DR Days Late" attached to the records, and, 16 of these DRs had "DRs Days Late" attached to the records. Three DRs had a status of "DR Approval Requested", two of which had "DR Days Late" attached the records. In addition, two DRs had a status of "DR Closed" and indicated they were entered in error.
    - In comparison to last quarter, please state if there is an increase or decrease of late Death Review closures for your CME: Increase, this quarter there were 21 DRs with a status of "DR Final" with "DR Days Late" attached to the record, compared to last quarter with 11 DRs that indicated days late were attached to the record. Additionally there were 35 DRs with a status of "DR In Process", of these, 16 of these DRs had "DRs Days Late" attached to the records. Two DRs had a status of "DR Approval Requested", with "DR Days Late" attached the records.
    - Please provide reasoning for the late entries: The Office of Training Investigations and Safety (OTIS) and Community Developmental Disability Programs (CDDPs) are responsible for approving and closing Death Reviews. Many CDDPs have attributed long waiting periods for death certificates and autopsy reports regarding overdue Death Reviews. The CMSS Unit is currently in discussion and working with OTIS regarding overdue DRs due to long waits from vital records.
    - What actions is your CME taking to remediate this, please list: This report will be shared with the CMSS Unit who supports the Mortality Review process and supports CMEs with this work. They also follow up with CMEs when there is a Death Review started but no corresponding Death SI entered into CAM. This report will also be accessible on the ODDS Providers and Partners website. It is important to note that this report is completed based on a data pull that uses the CAM field "Date/time Opened". In addition, ODDS is continuing to collaborate with our partners to raise concerns about wait times with vital statistics.
11. Has the Abuse Investigator been notified of all deaths from this quarter? The CDDPs who have submitted reports at the time of the ODDS Statewide Analysis

indicated that Abuse Investigators had been notified of all deaths in their CME. Several indicated N/A as they did not have deaths occur this quarter. ODDS will continue to follow the mortality review process and have conversations with OTIS. CDDPs have abuse investigators that work at the local level, who also work with OTIS on processing death reviews.

- Number of late death notifications your CME received this quarter: There were 46 DRs statewide that indicate the CME received the death report more than 1 business day after the date of death.
- Of the Death Reviews, how many had a concern of abuse associated with it? Of the 77 DRs entered, 35 DRs do not indicate if abuse or neglect was a factor in the death as this field is "blank" in these records and are still in process, two indicate they were entered in error, and 40 indicate that "Abuse or Neglect Not a Factor".

12. How many abuse intakes did your CME **enter into CAM** this quarter? 1,815 records were in CAM at the time of this report. Of these, 1,319 indicated an "Intake Type" of "Abuse Concern" and 496 "Intake Type" listed "No Abuse Concern".

- Of those intakes, how many investigations were opened? 1,680 intakes had a status of open at the time of this report. Additionally, 1,490 were "Closed at Intake", 110 were "Assigned for Investigation", 34 had a status of "Approval Requested", 13 had a status of "Intake in Process", 31 had a status of "Notification in Process" , 2 had a status of "Under Reconsideration" and 135 had a status of "Final".
  - Is this an increase or decrease from last quarter? Decrease, there were 1,756 intakes opened last quarter.
  - Number of abuse investigations completed timely? 42 Intakes indicate a status of "Final" with 55 days or less listed in the "Age" column in the report, which indicate the days opened in CAM.
  - Please describe the follow up actions your CME took or is taking to prevent reoccurrence. CDDPs have abuse investigators that work at the local level who also work with Abuse Investigator Coordinators (AICs) at OTIS.

IMT quarterly schedule

Please submit completed IMT reports to imt.submissions@odhsoha.oregon.gov by the associated due date. Thank you!

Quarter	Monthly schedule	IMT submission due	ODDS quarterly call-in
Q1	January 1- March 31	May 1	April
Q2	April 1 – June 30	August 1	July
Q3	July 1 – September 30	November 1	October
Q4	October 1 – December 31	February 1	January

Submission status for IMT reports

Totals for 2024 Q2

- Late: 7
- Missing: 0
- Timely: 42

Status by CME as of February 27, 2025

CME	Status
Baker CDDP	Late
Benton CDDP	Late
CIIS	Timely
Clackamas CDDP	Timely
Clatsop CDDP (Clatsop Behavioral Healthcare)	Timely
Columbia CDDP (Columbia Community Mental Health)	Timely
Community Counseling Solutions - Grant, Gilliam, Lake, Morrow, Wheeler	Late
Community Living Case Management - Coos	Timely
Community Living Case Management - Curry	Timely
Community Living Case Management - Douglas	Timely
Community Living Case Management - Josephine	Late
Community Living Case Management - Mid Columbia (Hood River, Sherman, Wasco)	Timely
Community Pathways	Timely

Connections Case Management - Coos	Timely
Connections Case Management - Curry	Timely
Connections Case Management - Douglas	Timely
Connections Case Management - Klamath	Timely
Creative Supports - Jackson & Josephine	Timely
Crook CDDP (Best Care Treatment Services)	Timely
Deschutes CDDP	Timely
Eastern Oregon Support Services Brokerage	Timely
Full Access	Timely
Full Access - High Desert	Timely
Harney CDDP (Symmetry Care)	Timely
Inclusion, Inc.	Late
Independence Northwest	Timely
Integrated Services Network	Late
Jackson CDDP	Timely
Jefferson CDDP (Best Care Treatment Services)	Late
Klamath CDDP	Timely
Lane CDDP	Timely
Lincoln CDDP	Timely
Linn CDDP	Timely
Malheur CDDP	Timely
Marion CDDP	Timely
Multnomah CDDP	Timely
ODDS Kids Residential	Timely

Polk CDDP	Timely
Resource Connections Mid Valley	Timely
Resource Connections South Valley	Timely
Self Determination Resources	Timely
Tillamook CDDP (Tillamook Family Counseling Center)	Timely
UCP Connections	Timely
UCP Mentors	Timely
Umatilla CDDP	Timely
Union CDDP (Center for Human Development, Inc)	Timely
Wallowa CDDP (Wallowa Valley Center for Wellness)	Timely
Washington CDDP	Timely
Yamhill CDDP	Timely