Office of Developmental Disabilities Statewide Review

Date of Meeting: 10/24/2023

Reporting Quarter: Quarter 3 (July 1 - September 30) Year Reviewed: 2023

ODDS is completing the statewide analysis review of CAM SI data using the same form Case Management Entities (CMEs) are required to use and report on quarterly. In 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 the statewide data and trends.

Statewide Serious Incident Data:

1. Number of SI's entered by the CME more than 7 days after becoming aware of the incident: 527
    - Number of SI's entered by the CME within 7 days of becoming aware of the incident: 3,462
    - In comparison to last quarter, please state if there is an increase or decrease of late entries for your CME: Increase, 477 SIs were entered more than 7 days after becoming aware last quarter.
    - Please provide reasoning for the late entries: This trend could be attributed to multiple factors. There were 76 enrollments this quarter for the CAM Serious Incident DD User Training in Workday. These could be newly hired case managers, or case managers taking it as a refresher. ODDS is not able to tell if the enrollments are linked to new or existing case managers. In addition, total SIs have increased over the previous two quarters. This could also contribute to the total number of late entries, if CMEs are having to provide training for new staff or provide staff refresher trainings.
    - What actions is your CME taking to remediate this, please list: ODDS Quality Management (QM)Team will continue to work with ODDS units who support CMEs including the Case Management Supports Services Unit on best practices for CAM entry. To gain further understanding of the potential volume of CME turn over, a request will be made to CAM Support for the number of activation and deactivation of CAM user licenses for CMEs.

2. Number of SI's not closed within 30 days of CME entry: 380
    - Number of SI's closed by the CME within 30 days of CME entry: 3,537
    - In comparison to last quarter, please state if there is an increase or decrease of late closures for your CME: This is a decrease, 436 SIs closed late last quarter.
    - Please provide reasoning for the late closures: This could be connected to CME staff completing the CAM training and closing the SIs timely within CAM. Multiple CMEs have identified in their IMT reports a number of retraining's have occurred within their specific CMEs. This could contribute to the decrease in late closures. In addition, SIs may be opened in one quarter and closed in the following quarter. Given that SIs have to be closed within 30 days of opening at the time of this report there may be some SIs that are still open exceeding the timeline of 30 days for closure.
    - What actions is your CME taking to remediate this, please list: QM will work with ODDS units who support CMEs including the Case Management Support Services Unit on best practices for CAM record maintenance. ODDS has provided additional venues for technical support for the IMT form and process this quarter. A technical support call in has been made available to CME partners as well as collaborating with the internal and external IMT workgroups.

3. Number of SI's entered by the CME with "No Recommended Action" selected: 1,669
    - Number of SI's entered by the CME with an identified Recommended Action other than "No Recommended Action": 2,402
    - In comparison to last quarter, please state if there is an increase or decrease of Recommended Actions being identified by your CME: This is an increase, there were 1,208 SIs with "No Recommended Actions".
    - Please provide any actions your CME is taking related to the identification of Recommended Actions in SI entry: At the last IMT Technical Assistance Call In, CMEs asked for clarification around Recommended Actions (RA). CMEs have reported that they document their follow-up actions in progress notes. ODDS understands that CMEs may be completing case management activities to mitigate the risk of a serious incident and documenting in the progress note and not in the SI entry to avoid duplication of documentation. Before an SI can be closed, a CME must identify the RA being taken. 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 is having internal conversations around Recommended Actions. ODDS has encouraged CMEs to document any actions or follow ups that has

occurred or still needs to occur related to the serious incident within the Recommended Action record.

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 SI's entered **this** quarter:
Death	86	73	74	2%
Suicide Attempts	37	43	40	1%
Act of Physical Aggression	219	214	295	7%
Safeguarding Intervention/Equipment Resulting in Injury	11	14	15	0.4%
Emergency Physical Restraint	23	26	25	0.6%
Unplanned Hospitalization	569	561	508	13%
Missing Person	58	89	60	1.5%
Emergency Medical Care	2,848	2,905	3,242	81%
Medication Error with Adverse Consequences	34	32	29	0.7%
Psychiatric Hospitalization	58	89	71	2%

5. When reviewing the SI category types reported, please identify the SI's that had an increase in this reporting period: At the statewide level the SI categories experiencing an increase are Death, Act of Physical Aggression, Safeguarding Intervention/Equipment Resulting in Injury, Emergency Medical Care (EMC).
   - Please describe the patterns your CME is seeing: When reviewing EMC SIs, it is apparent that CMEs are directly copying the text from PointClickCare (PCC) and no additional context is being added. Upon reviewing SIs in these categories, it is apparent that CMEs are entering SIs with incident dates that predate the current quarter being reported. It could be that they were just made aware of the incidents. When reviewing

the Death SIs, it also appeared there was duplication of SIs entered for at least one individual.

- Please describe the follow-up actions your CME is taking to prevent reoccurrence: ODDS QM will discuss observation of CMEs cutting and pasting acronyms and medical notes without further context from PCC into CAM at the next External IMT workgroup. QM will also discuss this at the next Internal IMT meeting to notify other internal ODDS partners. QM will also notify the Case Management Liaison Team regarding duplicative Death SIs.

6. When reviewing the SI category types experiencing an increase of reporting, are these SI's connected to the same provider(s) or location(s): When reviewing the data statewide, there does not appear to be significant patterns or trends with specific providers or locations. However, within each county it may be possible to observe patterns with the specific providers serving in each county and their service site locations.
   - Please describe the patterns your CME is seeing: Medicaid agency providers who have multiple locations across the state experienced multiple SIs within one specific category, generally they were not associated with the same location(s). CMEs are responsible for monitoring the providers and individuals within their counties. If a concerning pattern emerges CMEs address this at their level.
   - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QM did identify a few instances where there was a pattern with a specific provider and have since made internal ODDS units aware. Given that this is the first quarter this form as been used, ODDS will work with internal units to discuss emerging patterns and concerns as ODDS is made aware of them.

7. When reviewing the SI category types experiencing an increase of reporting, are these SI's connected to the same individual(s) experiencing frequent incidents? Across the state there were a select handful of individuals with reoccurring SIs in these categories.
   - Please describe the patterns your CME is seeing: There were several instances where one individual experienced reoccurring SIs in one category during the quarter. In one instance, the same individual accounted for 19% of all Physical Aggression SIs.
   - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QM has shared with the Case Management Support Services Unit regarding individuals with high SI volume.

8. Please share any concerns, successes or identify any patterns your CME has observed this quarter with providers: ODDS considers CMEs as providers in this analysis and across the state has observed that multiple CMEs are copying text and medical terminology from PCC into the SI record without adding additional details or context. It was also noted at several CMEs have been entering in SIs into CAM from 1-2 years ago. ODDS has maintained that best practice includes entering SIs as CMEs become aware of them. For example, if a CME conducts an internal audit and identifies that an SI entry did not occur as required, or perhaps the CME was not made aware of the incident timely, it is necessary to ensure that the entry is still made within CAM as soon as they are made aware.
   In reviewing the Q3 IMT Submissions from CMEs, several CMEs reported they were following up with providers in their local areas and documenting tangible action items. We also noticed this quarter many CMEs who historically submitted their IMT report late, submitted timely.
   - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QM 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. QM presented at the I/DD Conference in August on the IMT process as an additional avenue for technical assistance to CMEs and provided IMT related resources.

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 individual receiving services at the local level. However, in reviewing this data ODDS did observe some concerning trends regarding specific individuals as noted previously in this report.
   - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QM has shared with the Case Management Liaison Team regarding individuals with notably high SI count and concerning patterns.

☐ **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!

Statewide Abuse & Death Review Data:

Note: The questions below are intended to report on Abuse and Death Reviews. ODDS recognizes that the form contains an error. In the below questions regarding “Death SIs” these should be asking for “Death Reviews”.

ODDS is reporting on Death Reviews and Abuse in the following questions. ODDS has since updated question #10 to reflect the accurate terminology and updated “Death SI(s)” to “Death Review(s)”.

10. Number of Death SI’s entered this quarter: 84.
    - Number of Death SI’s entered more than 7 days after becoming aware of the incident: 23
    - In comparison to last quarter, please state if there is an increase or decrease of late entries for your CME: Last quarter, 43 Death Reviews were entered more than 7 days after becoming aware.
    - Please provide reasoning for the late entries: OTIS and CMEs are responsible for closing Death Reviews. The Case Management Support Services Unit supports the Mortality Review process and supports CMEs with this work.
    - What actions is your CME taking to remediate this, please list: This report will be shared with the Case Management Support Services Unit who support 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 shared via transmittal and accessible on the ODDS Providers and Partners website. Note: ODDS has since updated question #10 to reflect the accurate terminology and updated “Death SI(s)” to “Death Review(s)”.

11. Has the Abuse Investigator been notified of all deaths from this quarter? The CMEs who have submitted reports at the time of the ODDS Statewide Analysis indicated yes. 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 the Office of Training and Investigations and Safety (OTIS). Community Developmental Disability Programs (CDDPs) CMEs have abuse investigators that work at the local level, who also work with OTIS on processing death reviews.
    - Of the death Serious Incidents, how many had a concern of abuse associated with it? 0

12. How many abuse intakes did your CME enter into CAM this quarter? 1,598
    - Of those intakes, how many investigations were opened? 1,496

- Is this an increase or decrease from last quarter? Last quarter there was 1,531 abuse intakes. This is an increase.
- Please describe the follow up actions your CME took or is taking to prevent reoccurrence. Community Developmental Disability Programs (CDDPs) CMEs have abuse investigators that work at the local level who also work with OTIS.

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

Thank you!

IMT Quarterly Schedule			
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

The following table outlines Case Management Entities (CMEs) submission status for the 2023 Q3 IMT report. If an IMT report was submitted after the due date of 11/1/2023, it is considered late.

CME IMT Submissions Status Report*	Count of Q3 Reports Received
Timely	**31**
CIIS	1
Columbia CDDP (Columbia Community Mental Health)	1
Community Living Case Management - Coos	1
Community Living Case Management - Curry	1
Community Living Case Management - Josephine	1
Community Living Case Management - Mid Columbia (Hood River, Sherman, Wasco)	1
Creative Supports - Jackson & Josephine	1
Crook CDDP (Best Care Treatment Services)	1
Deschutes CDDP	1
Eastern Oregon Support Services Brokerage	1
Full Access - High Desert	1

Harney CDDP (Symmetry Care)	1
Inclusion, Inc.	1
Independence Northwest	1
Jackson CDDP	1
Klamath CDDP	1
Lane CDDP	1
Linn CDDP	1
Malheur CDDP	1
Marion CDDP	1
Multnomah CDDP	1
ODDS Kids Residential	1
Polk CDDP	1
Resource Connections Mid Valley	1
Resource Connections South Valley	1
Tillamook CDDP (Tillamook Family Counseling Center)	1
UCP Connections	1
Umatilla CDDP	1
Union CDDP (Center for Human Development, Inc)	1
Washington CDDP	1
Yamhill CDDP	1
Missing	**6**
Baker CDDP	1
Benton CDDP	1
Community Counseling Solutions - Grant, Gilliam, Lake, Morrow, Wheeler	1
Community Living Case Management - Douglas	1
Jefferson CDDP (Best Care Treatment Services)	1
Self Determination Resources	1
Late	**11**
Clackamas CDDP	1
Clatsop CDDP (Clatsop Behavioral Healthcare)	1
Community Pathways	1
Connections Case Management - Coos	1
Connections Case Management - Curry	1
Connections Case Management - Douglas	1
Connections Case Management - Klamath	1
Full Access	1
Integrated Services Network	1
Lincoln CDDP	1
Wallowa CDDP (Wallowa Valley Center for Wellness)	1

***Submission Data as of 12-28-2023**