Office of Developmental Disabilities Services
Statewide Review

Reporting Quarter: Quarter 2 (April 1 - June 30) **Year Reviewed**: 2024

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. 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.

Serious Incident Data:

1. Number of SIs entered by the CME **more than 7** days after becoming aware of the incident: 682 (15%)
    - Number of SIs entered by the CME **within 7 days** of becoming aware of the incident: 3,927 (85%)
    - In comparison to last quarter, please state if there is an increase or decrease of late entries for your CME: Increase, there were 543 SIs entered late last quarter which accounted for 13% of SIs entered compared to 682 SIs entered late this quarter making up 15% of the SIs entered. When reviewing the data ODDS noticed there were two CMEs with zero late entries this quarter. Although there is an increase of late entries, ODDS wants to recognize this positive trend in this report.
    - Please provide reasoning for the late entries: There are multiple factors that could impact this trend. There was an 8.7% increase in the total number of SIs entered this quarter, which could account for the higher number of late entries this quarter. Five CMEs accounted for 358(52%) of the late SI entries this quarter.
    - 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 continues to work with CAM Support on obtaining a report on the number of activated and deactivated CAM user licenses for CMEs to better understand the potential volume of turnover and newly hired case managers across the state.

2. Number of SIs **not closed within 30 days** of CME entry: 525 (11%), additionally out of these 151 (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: 4,084 (89%)
    - In comparison to last quarter, please state if there is an increase or decrease of late closures for your CME: Increase, there were 335 SIs closed late last quarter which accounted for 8% of SIs compared to 525 closed late this quarter, making up 11% of SIs. Although there is an increase of SIs closed late this quarter, ODDS wants to acknowledge this there were ten CMEs who had zero SIs that were closed late this quarter.
    - Please provide reasoning for the late closures: There are several factors to consider. This quarter five CMEs accounted for 239 late closures (46%). These five CMEs had 35 or more late closures for the quarter. 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. 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 were 151 SIs listed as "SI in process" within CAM. At the time data was pulled, the SIs listed as "SI in process", are shown as late closures due to functionality in CAM that auto calculates the due date.
    - 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. This work is being completed in an effort to support CMEs statewide with the development of additional resources related to IMT. QI will follow up with the CAM Support Team to verify the functionality for how SIs closed late is calculated is functioning properly.

3. Number of SIs entered by the CME **with "No Recommended Action"** selected: 1,743 (38%)
    - Number of SIs entered by the CME with an identified Recommended Action **other than "No Recommended Action"**: 2,782 (60%)
    - 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 1,272 SIs with "No Recommended Action" selected last quarter which account for 35% of SIs. While reviewing the data this quarter ODDS observed a difference in the number of SIs associated with RAs, from the overall number of SIs reported this quarter. The overall

number of SIs reported this quarter is 4,609, when reviewing the data report for RA's the number of SIs was 4,512. There were 13 SIs that had multiple RAs, these SIs were only counted once in this count. While SIs can have multiple RAs attached, this difference highlights a higher number of SIs reported this quarter than SIs associated with RAs. ODDS is in the process of reviewing and evaluating the reports within CAM to ensure data integrity and to identify if this is an isolated issue.

- Please provide any actions your CME is taking related to the identification of Recommended Actions in SI entry: ODDS observed that 51% of SIs that had an identified RA did not have a completion date for the RA included in the record. Several CMEs have reported that they continue to document their follow-up actions in progress notes. Before any 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 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 will review the recommended action report in CAM and determine if additional fields are needed to provide additional context for further follow up action by CME and/or ODDS. QI has contacted CAM Support to review the reports functionality.

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	73	71	105	2%
Suicide Attempt	39	43	67	1.5%
Act of Physical Aggression	236	253	279	6%
Safeguarding Intervention/Equipment Resulting in Injury	15	9	23	.5%
Emergency Physical Restraint	15	37	28	.6%
Unplanned Hospitalization	501	584	607	13%
Missing Person	59	70	94	2%

Emergency Medical Care	3,018	3,444	3,673	80%
Medication Error with Adverse Consequences	25	26	15	.3%
Psychiatric Hospitalization	61	72	105	2%
Total SIs entered	3,728	4,240	4,609	

5. When reviewing the SI category types reported, please identify the SIs that had **an increase** in this reporting period: All SI categories except Medication Errors with Adverse Consequences and Emergency Physical Restraint, had a reported increase.
    - Please describe the patterns your CME is seeing: This quarter there was an 8.7% increase in the total number of SIs entered. It is important to note that the total SIs listed in the table above reflect all SIs entered in Q2. Each SI can have multiple SI categories associated within the SI entry/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 with the CMSS Unit.

6. When reviewing the SI category types experiencing **an increase** of reporting, are these SIs connected to the **same provider(s) or location(s)**?: Medicaid agency providers who have multiple licensed site locations across the state, may experience multiple SIs within one specific category. When reviewing the statewide data ODDS noticed that there were 12 Medicaid Agencies with 25 or more SIs that occurred at one of their licensed/endorsed sites. When looking at the site specific locations there were 17 licensed/endorsed sites with ten or more SIs associated with the specific site. Of these 17 sites, nine of them are associated with the same Medicaid Agencies identified above with 25 or more SIs this quarter. In addition there were 2,020 (44%) SIs where a Responsible Personal Support Worker (PSW) was selected in the SI, but the specific PSW was not listed in the SI.
    - Please describe the patterns your CME is seeing: As noted above, when reviewing the data statewide, ODDS observed several provider/locations that experienced multiple SIs. Within each CME it may be possible to observe additional patterns with the specific providers serving in each county and their service site locations. CMEs are responsible for monitoring the providers and individuals within their counties. If a concerning pattern emerges CMEs are responsible for addressing this at their level and notifying ODDS when necessary.
    - 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 CMSS team and the internal IMT workgroup.

7. When reviewing the SI category types experiencing **an increase** of reporting, are these SIs connected to the **same individual(s)** experiencing frequent incidents? Across the state there were several individuals with reoccurring SIs in the SI categories experiencing an increase this quarter.
    - 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 CMSS team and the internal 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 current OAR language, given the nature of the incident a provider has specific timelines that must be adhered to when reporting incidents to a CME, ranging from one business day to within five business days. From here, the CMEs have seven calendar days to enter the SI into CAM. This quarter ODDS noted that there were 840 SIs that were not reported to CMEs within five days, and 114 SIs were reported to CMEs over 30 days from date of incident. There were 3,350 SIs reported to CMEs within five days and of these records 2,812 SIs were entered into CAM within seven days of the CME being notified.
    - 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.

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 in their geographical service area. However, in reviewing this data QI did make observations at the statewide level as noted previously in this report. When reviewing the timeliness of CME IMT submissions, for Q2, 39 CMEs submitted their reports timely, in comparison to Q1 where 37 CMEs submitted their reports timely. At the time of this report there are two missing CME submissions for Q2.
    - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QI met with CMSS Unit and the Quality Assurance (QA) and implemented an agreed upon process for follow up with CMEs

regarding missing submissions and non-compliance with the IMT process. This information will be shared with the internal IMT workgroup as well as at ODDS meetings as needed.

☐ **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 Data:

10. Number of Death Reviews **entered this quarter**: 99 Death Reviews (DRs) were entered into CAM this quarter at time of this report.

- Number of Death Reviews entered within one business day after becoming aware of the death: At the time of this report, 28 (28%) DRs were entered timely this quarter meaning that 71 (72%) DRs were entered "late".
- Number of Death Reviews completed with the required timelines of 55 days: At the time of this report, 35 DRs had a status of "DR Final" with no "DR days late" attached to the record meaning the DRs were completed timely, 21 DRs had a status of "DR Final" and had "DR days late" attached to the record, meaning they were closed late. There were 41 DRs still pending a decision and show a status of "DR in process". In addition, there were two DRs with a status of "DR Closed" and the report indicates the DR was 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: This is a decrease as last quarter 23 DRs were closed late compared to 21 this quarter.
- 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 in regards to overdue Death Reviews. The CMSS Unit is currently in discussion and working with OTIS in regards to 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 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 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 collaborating 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.
    - Of the Death Reviews, how many had a concern of abuse associated with it? At time of report, one DR indicated "Concern of Abuse or Neglect" and 41 DRs were in process and the closure reason has not yet been selected. This report will be shared with the CMSS Unit who support the Mortality Review process and supports CMEs with this work.

12. How many abuse intakes did your CME enter into CAM this quarter? 1,775 intakes were completed statewide this quarter.
    - Of those intakes, how many investigations were opened? 1,692 intakes were opened, 1,485 were Closed at Intake,150 have been Assigned for Investigation, 10 have been marked Intake in Process, 36 have been marked Notification in Process, 11 have been marked as Approval Requested, and 83 have been closed as Final.
    - Is this an increase or decrease from last quarter? Decrease, last quarter there were 1,774 intakes opened were entered.
    - 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.

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 CMEs submission status for the 2024 Q2 IMT report.

CME IMT Submissions Status Report*	Count of Q2 Reports Received
Late	**8**
Benton CDDP	1
Community Counseling Solutions - Grant, Gilliam, Lake, Morrow, Wheeler	1
Deschutes CDDP	1
Eastern Oregon Support Services Brokerage	1
Integrated Services Network	1
Jefferson CDDP (Best Care Treatment Services)	1
Lincoln CDDP	1
UCP Connections	1
Missing	**2**
Baker CDDP	
Self Determination Resources	
Timely	**39**

CIIS	1
Clackamas CDDP	1
Clatsop CDDP (Clatsop Behavioral Healthcare)	1
Columbia CDDP (Columbia Community Mental Health)	1
Community Living Case Management - Coos	1
Community Living Case Management - Curry	1
Community Living Case Management - Douglas	1
Community Living Case Management - Josephine	1
Community Living Case Management - Mid Columbia (Hood River, Sherman, Wasco)	1
Community Pathways	1
Connections Case Management - Coos	1
Connections Case Management - Curry	1
Connections Case Management - Douglas	1
Connections Case Management - Klamath	1
Creative Supports - Jackson & Josephine	1
Crook CDDP (Best Care Treatment Services)	1
Full Access	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 Mentors	1
Umatilla CDDP	1
Union CDDP (Center for Human Development, Inc)	1
Wallowa CDDP (Wallowa Valley Center for Wellness)	1
Washington CDDP	1
Yamhill CDDP	1

***Submission Data as of September 25, 2024.**