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.

Reporting Quarter

Quarter 3 (July 1 - September 30)

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: 739 (16%)
    - Number of SIs entered by the CME **within 7 days** of becoming aware of the incident: 3,990 (84%). This number includes a small number of SIs with a “Report Received by CME” date that occurs after it was entered into CAM. QI will be following up with CAM support to ensure data validation is functioning correctly.
    - In comparison to last quarter, please state if there is an increase or decrease of late entries for your CME: Increase, there were 682 SIs entered late last quarter which accounted for 15% of the SIs entered, compared to 739 SIs entered late this quarter making up 16% of the SIs entered.
    - Please provide reasoning for the late entries: There are multiple factors that could impact this trend. There was a 3% 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 468 (63%) 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: 529 (11%), additionally out of these 114 (2%) 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: 4,200 (89%)
    - In comparison to last quarter, please state if there is an increase or decrease of late closures for your CME: Increase, there were 525 SIs closed late last quarter compared to 529 SIs closed late this quarter. When comparing this quarter and last quarter's records, both quarters showed 11% of SIs were closed late.
    - Please provide reasoning for the late closures: There are several factors to consider. This quarter seven CMEs were responsible for 337 of the late closures (64%). These seven CMEs had 20 or more late closures for the quarter. This quarter, 28 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.
    - 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.

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"**: 2,903 (62%)
    - 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 2,782 Recommended Actions 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 83 SIs between the Recommended Action

report and the Serious Incident report in CAM. Based on the reported data, there were no SIs that had multiple RAs attached to it.

- Please provide any actions your CME is taking related to the identification of Recommended Actions in SI entry: ODDS will continue to work with CAM support to ensure the 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.

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	71	105	74	2%
Suicide Attempt	43	67	58	1%
Act of Physical Aggression	253	279	263	6%
Safeguarding Intervention/Equipment Resulting in Injury	9	23	18	.4%
Emergency Physical Restraint	37	28	21	.4%
Unplanned Hospitalization	584	607	587	12%
Missing Person	70	94	97	2%
Emergency Medical Care	3,444	3,673	3,859	82%
Medication Error with Adverse Consequences	26	15	28	.6%
Psychiatric Hospitalization	72	105	116	2%
Total SIs entered	4,240	4,609	4,729	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 Missing Person with a 3% increase, Emergency Medical Care (EMC) with a 5% increase, Medication Error with Adverse Consequences with an 87% increase and Psychiatric Hospitalization with an 10% increase. It is important to note that these percentages are calculated using the increased amount of SIs in each category from quarter 2 to quarter 3.
    - Please describe the patterns your CME is seeing: There was a 3% 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 Q3. 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. ODDS anticipates the rule updates will be reflected in the data started in Q4 of 2024.

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. Upon reviewing this set of data, only 3% of SIs were reported by PSWs. There are some reoccurring SIs connected to the same provider(s) and location(s) but are also connected to a specific individual(s).When looking at Suicide Attempt SIs for the quarter, 55% of SIs did not have an associated provider. When looking at Missing Person SIs, one provider was associated with 26% of the SIs in this category. Three individuals accounted for the 26 SIs served by this provider. CMEs are responsible for oversight of their geographical service area.
    - Please describe the patterns your CME is seeing: When looking at the four 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 CMSS team and the internal 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 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 the total SIs this quarter ODDS made the following observations: 79% of incidents were reported to CMEs within 5 days of the incident. 56% of SIs identified there was not a responsible provider at the time of the incident. ODDS received all CME Q3 IMT reports timely 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 twenty individuals across the state experienced more than 10 incidents this quarter.
   - Please describe the follow-up actions your CME is taking to prevent reoccurrence: QI will share this information with the CMSS unit and internal 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**: 65
    - Number of Death Reviews entered within **one business** day after becoming aware of the death: 57 (88%)
    - Number of Death Reviews completed with **the required timelines of 55 days**: At the time of this report, 42 DRs had a status of "DR Final", 31 DRs had a status of "DR Final" with no "DR days late" attached to the record; 11 DRs had a status of "DR Final" with "DR days late" attached to the record; 21 DRs are still pending a decision and show a status of "DR in process" and 10 of the DRs in process indicate "DR days late" within record; two DRs have a status of "DR approval requested", one of these DRs indicates a status of "DR days late".
    - In comparison to last quarter, please state if there is an increase or decrease of late Death Review closures for your CME: Decrease, this quarter there were 11 DRs closed late, compared to 21 last quarter. Additionally, there were 10 DRs in process that indicated "DR days late". Given that these had a status of pending, they were not considered in the DRs closed late for this report.
    - 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 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.
    - Of the Death Reviews, how many had a concern of abuse associated with it? At the time of this report, three DRs had a "Concern of Abuse or Neglect" and 21 DRs are still in process and a closure reason has not yet been identified.
12. How many abuse intakes did your CME enter into CAM this quarter? 1,814
    - Of those intakes, how many investigations were opened? 1,756 intakes were opened, 1,465 were "Closed at Intake", 144 have been "Assigned for Investigation, 17 had a status of "Approval Requested", 22 had a status of "Intake in Process",104 had a status of "Notification in Process", four had a status of "Under Reconsideration" and 58 had a status of "Final".
    - Is this an increase or decrease from last quarter? Increase, there were 1,692 intakes opened last quarter compared to this quarter.
    - 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 16th
Q2	April 1 – June 30	August 1	July 16th
Q3	July 1 – September 30	November 1	October 15th
Q4	October 1 – December 31	February 1	January 14th

Submission Status for CME IMT Reports

Totals for 2024 Q3

- Late: 1
- Missing: 0

- Timely: 48

Status by CME as of 1/9/2025

CME	Status
Baker CDDP	Timely
Benton CDDP	Timely
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	Timely
Community Living Case Management - Coos	Timely
Community Living Case Management - Curry	Timely
Community Living Case Management - Douglas	Timely
Community Living Case Management - Josephine	Timely
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.	Timely
Independence Northwest	Timely
Integrated Services Network	Timely
Jackson CDDP	Timely
Jefferson CDDP (Best Care Treatment Services)	Timely
Klamath CDDP	Timely
Lane CDDP	Timely
Lincoln CDDP	Late
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