

2006-2007 YEAR IN REVIEW

Risk Management and Mitigation

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According to Title 17 of the California Code of Regulations, vendors and long-term health care facilities must report certain “special incidents” that occur to consumers with developmental disabilities. This year-end report summarizes California’s rates of reported special incidents during the fiscal year 2006-2007.

The California Department of Developmental Services (DDS) serves over 200,000 individuals with developmental disabilities, relying on a network of 21 regional centers to plan, coordinate, and monitor an array of services. In 2001, DDS initiated a comprehensive risk prevention, mitigation, and management system as one cornerstone of quality services for consumers living in the community. As part of this system, DDS tracks adverse events that occur to consumers with developmental disabilities. Title 17 of the California Code of Regulations mandates that vendors and long-term health care facilities report these events, known as special incidents, to the regional centers, which in turn report them to DDS. Title 17 defines seven categories of special incidents:

- Missing person
- Reasonably suspected abuse/exploitation
- Reasonably suspected neglect
- A serious injury or accident
- Any unplanned hospitalization
- Death
- Victim of crime

This year-end report summarizes California’s rates of reported special incidents during the fiscal year 2006-2007. It delineates

special incident rates by type, comparing them with incident rates from the previous fiscal year. The rates and graphs presented in this report were constructed using data from the Special Incident Reporting (SIR) System from January 2002 through June 2007, augmented with three additional data sources maintained by DDS:

1. The Client Master File (CMF)
2. The Client Development Evaluation Report (CDER)
3. The Early Start Report (ESR).

Acumen, the department’s risk management contractor, compiled this report based on statistical analyses that measure a consumer’s risk of experiencing a special incident. The report concludes with a discussion of how DDS, Acumen, and the regional centers are working to ensure effective risk management practices to prevent the occurrence of special incidents.

The number of reported special incidents increased slightly in FY06/07, but the overall mortality rate decreased.

Table 1
Reported Special Incidents for DDS Consumers

	FY 05/06	FY 06/07
Total Number of Consumers	230,114	239,451
Total Number of Reported Incidents	16,389	17,280
All Incidents per 1000 Consumers	71.2	72.2
Deaths per 1000 Consumers	7.3	6.7

Key Findings:



- The number of consumers served by regional centers in FY06/07 rose 4% compared to the previous fiscal year, while the number of reported special incidents grew at a slightly faster rate.
- At 72.2 incidents per 1000 consumers, the number of reported incidents was higher in FY06/07 than in the previous year.
- The number of deaths per 1000 consumers was lower in FY06/07 than in the previous year.
- California's overall mortality rate appears to be lower than rates published by other states, although the populations served may differ. The reported 2006 mortality rate in Connecticut was 13.3 deaths per 1000, while Massachusetts' reported mortality rate (for adult consumers) was 16.6 deaths per 1000.

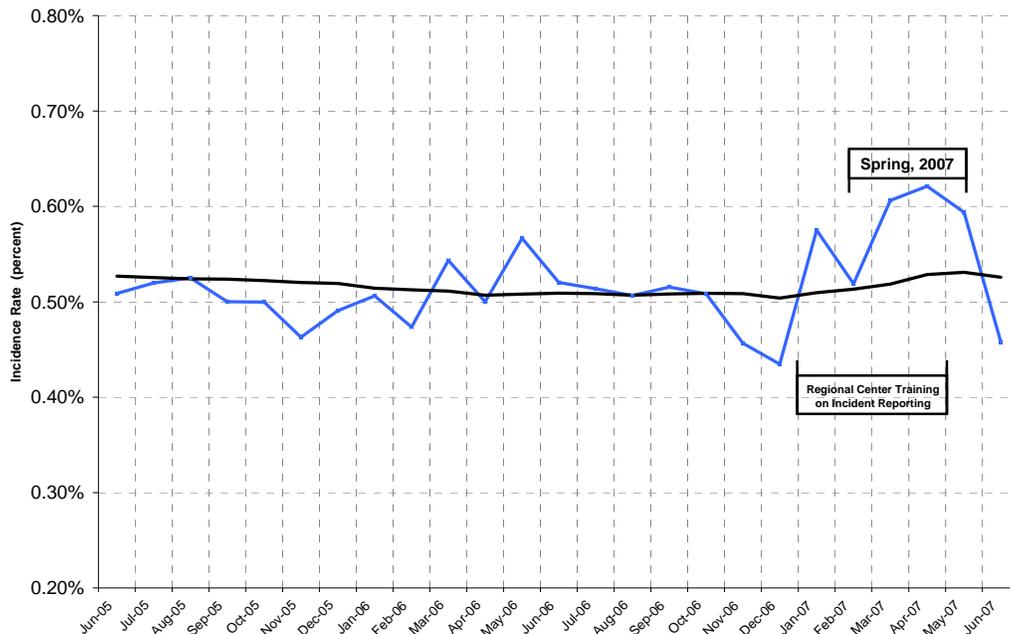
More About These Data

Total Number of Consumers is the number of different individuals who were ever served by DDS during FY06/07. This number is larger than the number of individuals served by DDS in any one month. This total includes consumers living in the community – that is, consumers receiving care from a regional center not residing in a Developmental Center or state-operated facility.

Connecticut mortality data includes all individuals (adults and children) supported by the Department of Mental Retardation Connecticut. The *Connecticut Mortality Annual Report (2006)* is available online: <http://www.ct.gov/DDS/cwp/view.asp?a=2042&q=391320>. Massachusetts mortality data includes all adults over age 18 served by the Department of Mental Retardation and listed in the Consumer Registry System Massachusetts. The *2006 Mortality Report* for Massachusetts can also be accessed online: <http://www.mass.gov/Eeohhs2/docs/dmr/mortalityreport2006.pdf>

The year-to-year rise in reported special incidents was most likely a result of expanded regional center training on incident reporting.

Figure 1: Statewide Non-Mortality Rates, DDS Consumers Case-Mix Adjusted Monthly Rates since December 2005



Key Findings:



- Monthly incident rates that control for changes in the characteristics of the consumer population show that the increase in reported incidents is concentrated in the spring of 2007.
- Between January and April 2007, the regional centers provided training to staff and service providers in a statewide effort to assure more consistent reporting among the 21 regional centers.

More About These Data

The black line above represents a 12-month moving average. It is calculated by taking an average of statewide mortality rates from the most recent 12-month period. The blue line represents the share of consumers statewide who experience one or more special incidents in a month. The lines shown on this graph account for differences in consumer characteristics as well as changes in the characteristics of the consumer population over time. This approach, called “case-mix adjustment,” controls for consumer characteristics such as age and medical condition, and removes these effects from the calculated trend.

Reported incident rates increased for several incident types, although not for the most common category, unplanned hospitalizations.

Table 2: Breakdown of Non-Mortality Special Incidents by Type, FY06/07

	Share of Non-Mortality Incidents	Avg. Monthly Incident Rate FY06/07	Change in Incident Rate from FY05/06
Unplanned Hospitalization	39%	0.21%	-2% ↓
Injury	28%	0.16%	+7% ↑
Suspected Abuse	14%	0.08%	+10% ↑
Suspected Neglect	5%	0.03%	+11% ↑
Missing Person	8%	0.04%	-1% ↓
Victim of Crime	6%	0.04%	+13% ↑

Key Findings:

- Reported rates of unplanned hospitalization fell from the previous year, although they continue to account for the greatest share of non-mortality special incidents. Unplanned hospitalization and injury account for almost 70% of all non-mortality special incidents.
- Less frequent special incident types had increased reporting rates compared to the last period. Rates of suspected abuse, suspected neglect, and victim of crime increased over 10% from a very small base.
- The increase in special incidents appears to be closely related to regional center trainings on incident reporting that occurred in the spring of 2007.

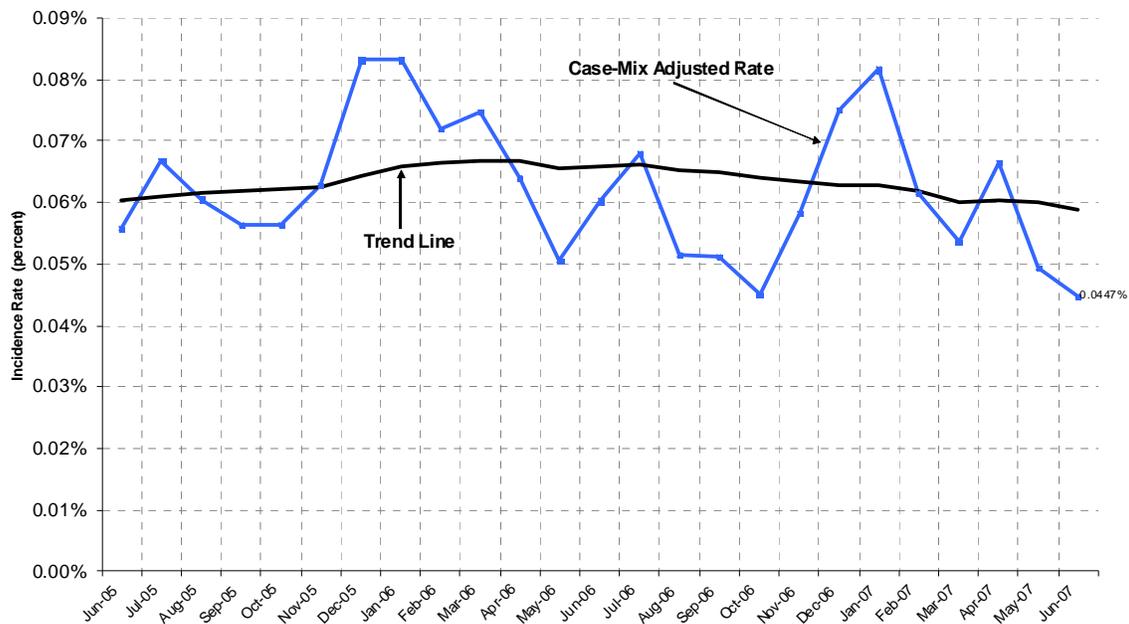
More About These Data

During the last fiscal year, all 21 Regional Centers participated in trainings to guide regional center staff in completing special incident reports. The trainings were part of the Reporting Alignment Project (RAP), whose objective was to ensure that regional centers reported special incidents consistently with each other and with state regulations. Following the RAP, many of the regional centers (16 of 20 respondents) indicated changes to their reporting practices. In particular, many indicated changes to what they considered reportable as “under vendored care.” Title 17, Section 54327 requires “all vendors and long-term health care facilities to report to the regional center [certain] special incidents,” with “vendor” defined as a habilitation services provider that has a state-issued vendor identification number. A survey of regional centers revealed that for many of them, the trainings refined their understanding of which incidents they consider reportable as “under vendored care,” possibly accounting for the spring 2007 rise in non-mortality special incidents.

“Monthly Incident Rate for FY06/07” refers to the rate of consumers statewide who experience one or more incidents in an average month. Rates are case-mix adjusted (refer to Page 3 for description).

Controlling for consumer characteristics, the mortality rate is trending downward, although a strong seasonal component remains.

Figure 2: Mortality Incidents, Statewide Case-Mix Adjusted Monthly Rates since June 2005



Key Findings:

- Mortality rates during FY06-07 followed trends seen in prior years; rates dipped during summer-fall season and spiked in the winter.
- Like the year before, this year's mortality rates were highest between December and February.
- Over the course of the fiscal year, the trend line (black) has steadily decreased.

More About These Data

The trend line (black line) is the monthly mortality rate averaged over the latest 12 month period. The trend is calculated by taking the average of the *Case-mix Adjusted Rate* (blue line) for the previous twelve-month period. The lines in the graph above also use case-mix adjustment, as described on the bottom of page 3.

Substantial new activities have focused on monitoring special incidents, as well as promoting best practices.

Activities:

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- Regional centers receive graphs each month that allow them to identify significant increases in special incident rates.
 - Starting in FY07/08, regional centers are reporting back findings from their reviews of any identified jumps in incident rates.
 - These reviews will provide information in greater depth about any unusual increases in incident rates
 - This information will help guide risk management activities.
 - To reduce incidents, regional centers have participated in trainings drawn from the experiences of seven pilot regional centers using multidisciplinary team practices to reduce rates of hospitalization.
 - Acumen publishes articles and presentations each month on www.ddssafety.net, geared toward consumers, their families, and their support providers. Acumen also publishes *The DDS Safety Net*, a quarterly newsletter for direct service providers. Both the website and newsletter offer materials geared towards keeping consumers healthy and safe, based on needs determined by statewide rates of special incidents.
 - Along with clinical staff from regional centers, Acumen is developing a set of best practice guidelines for regional center mortality reviews.