



Special Incident Trends

Semiannual Report submitted to the California Department of Developmental Services

January – June 2017

Report prepared: October 2017

ABOUT THIS REPORT

As one element of risk management and quality assurance, the California Department of Developmental Services (DDS) and California's network of regional centers monitor the occurrence of adverse events, captured through Special Incident Reports (SIR), to identify trends and develop strategies to prevent and mitigate risks. As required by Title 17, Section 54327 of the California Code of Regulations, vendors and long-term health care facilities report occurrences of suspected abuse, suspected neglect, injury requiring medical attention, unplanned hospitalization, and missing persons, if they occur when an individual is receiving services funded by a regional center (under vendored care). In addition, any occurrence of mortality or an individual being the victim of crime must be reported whether or not it occurred while they were under vendored care. Because of these requirements, mortality incidents are reported for all individuals served by DDS, but most non-mortality incidents are reported among individuals residing in out-of-home care settings. These include licensed care facilities, Family Home Agencies (FHA), Independent Living Services (ILS), and Supported Living Services (SLS).

This report summarizes incident rates for individuals served by DDS between January 2017 and June 2017. Findings on mortality incidents include all individuals actively served by regional centers, except those residing in developmental centers. Findings on non-mortality incidents focus on individuals in out-of-home care.



KEY FINDINGS

- The case-mix adjusted mortality rate decreased by nearly 10% compared to the same period last year.
- Mortality rates declined in most age groups compared to the same period last year.
- The case-mix adjusted non-mortality rate increased compared to the same period last year.
- The non-mortality rate decreased for children ages 13 to 21 and increased for adults ages 32 and older compared to the same period last year.

The statistics and graphs presented in this report were constructed using data reported in the SIR system through June 2017. Incident counts may differ from previous reports due to SIRs being added or reclassified as non-reportable. The SIR data are augmented with three additional data sources maintained by DDS: the Client Master File (CMF), the Client Development Evaluation Report (CDER), and the Purchase of Service (POS).

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I. SUMMARY OF MORTALITY AND NON-MORTALITY INCIDENTS

Between January and June 2017, almost 310,209 individuals living in the community received services from a regional center. During the period, there were more than 11,000 special incidents reported for these individuals, including 1,027 deaths and 10,103 non-mortality incidents. Since non-mortality SIRs are required primarily for incidents that occur under vendored care, 90 percent of non-mortality incident reports involve individuals living in out-of-home care settings. DDS served 63,378 people living in such settings this period.

Table 1: Reported Incidents for Individuals Served by DDS, January – June 2017 Compared to January – June 2016

	January - June 2016 (Last Year)	January - June 2017 (Current Period)
Total Number of Individuals, including Early Start ¹	295,919	310,209
Reported Mortality and Non-Mortality Incidents, including Early Start	10,720	11,130
Number of Deaths, including Early Start	1,103	1,027
Deaths per 1,000 Individuals, including Early Start	3.73	3.31
Number of Individuals, excluding Early Start or Below 36 Months	259,463	269,937
Number of Deaths	1,050	985
Deaths per 1,000 Individuals	4.05	3.65
Out-of-Home Individuals	63,162	63,378
Number of Non-Mortality Incidents	8,710	9,164
Non-Mortality Incidents per 1,000 Individuals ²	137.9	144.6

Data as received through July 2017. Mortality SIRs that did not occur under vendored care are most likely to be added later.

¹Active and Early Start (<36 months) caseload as reported by DDS for final month of the period.

²One person can have multiple non-mortality incidents in a period.

THE MORTALITY RATE DECREASED COMPARED TO THE SAME PERIOD LAST YEAR.

The mortality rate is generally higher from January-June each year, due to seasonal differences in respiratory illnesses and other health conditions. Therefore, we compare rates in each semi-annual period to rates in the same period in the previous year. Above, we compare January – June 2017 to January – June 2016. The first panel of Table 1 reports the mortality rate measured as the number of deaths per 1,000 individuals served by DDS. In the January-June 2017 period, this rate was 3.31, 11% lower than in the same period last year, at 3.73. (This difference is statistically significant.) Note, however, that there are sometimes delays in deaths being reported to DDS, particularly for individuals residing with parents or guardians, so the number of deaths for this period may increase in subsequent reports.

Our more detailed mortality analyses exclude children under three and/or those served in the Early Start program. There are two main reasons for this exclusion. First, children served by Early Start may not qualify for DDS services after age three, since the Early Start Program provides early intervention services for children with developmental delays or conditions that put them at high risk of developmental delays or disabilities. These children are not yet, and may never be, diagnosed with a developmental disability. Second, there are substantial differences in the data collected for Early Start compared to other DDS services, which makes it difficult to conduct combined analyses. There is a

MORTALITY AND NON-MORTALITY INCIDENTS

comparable pattern of rates over time, however, with a 10% decline for this period relative to the same period a year ago.

THE NUMBER OF NON-MORTALITY INCIDENTS PER 1,000 INDIVIDUALS WAS 5% HIGHER THIS PERIOD THAN IN THE SAME PERIOD LAST YEAR.

Non-mortality special incidents include missing person, suspected abuse, suspected neglect, medication error or serious injury, unplanned medical or psychiatric hospitalization, victim of crime, and death. In this semiannual period, there were approximately 145 non-mortality incidents per 1,000 out-of-home individuals served by DDS, up from the 138 incidents per 1,000 in the same period last year. The difference between the non-mortality incident rate this period compared with the same period last year is statistically significant.

II. MORTALITY INCIDENT FINDINGS

MORTALITY RATES DECLINED IN MOST AGE GROUPS IN THIS SEMI-ANNUAL PERIOD COMPARED TO THE SAME PERIOD LAST YEAR.

The mortality rate, measured as deaths per 1,000 individuals, increased with the age of the individuals this period. As shown in Table 2, mortality rates were lowest for children 3-13. Across age groups, the mortality rate was similar to or lower in the January-June 2017 period than in the same period a year before.

Table 2: Mortality Incidents for Individuals Served by DDS Age 3 and Above, by Age Group, January – June 2017 Compared to January- June 2016

Age in Years	Share of Individuals Jan-Jun 2017	Number of Deaths Jan-Jun 2017	Deaths per 1,000 Individuals Jan-Jun 2017	Deaths per 1,000 Individuals Jan-Jun 2016
3 to 13	31%	50	0.6	0.9
14 to 21	20%	61	1.2	1.5
22 to 31	20%	98	1.9	1.9
32 to 41	11%	86	3.0	3.5
42 to 51	8%	118	5.8	6.1
52 to 61	7%	242	13.2	13.0
62 or older	4%	330	28.6	32.8

*Data as received through July 2017. Rates for the same period last year are updated to include any additional mortality SIRs.

MORTALITY RATES DECLINED IN ALL RESIDENCE TYPES EXCEPT SKILLED NURSING.

Consistent with the predominance of young people in this residential setting, the mortality rate is lowest for those who live at home. The mortality rate is highest for individuals who live in Skilled Nursing Facilities (SNF), reflecting their significant health issues. Rates for other residential care settings, including Independent/Supported Living Services (ILS/SLS), Community Care Facilities (CCF), and Intermediate Care Facilities (ICF), fall in between these two extremes.

Table 3: Mortality Incidents for Individuals Served by DDS Age 3 and Above, by Residence Type, January – June 2017 Compared to January – June 2016

Residence Type	Share of Individuals Jan-Jun 2017	Number of Deaths Jan-Jun 2017	Deaths per 1,000 Individuals Jan-Jun 2017	Deaths per 1,000 Individuals Jan-Jun 2016
Home of Parent/Guardian/Relative	76%	319	1.6	1.8
Independent/Supported Living Services (ILS/SLS)	10%	124	4.8	5.0
Community Care Facilities (CCF)	9%	227	9.6	10.3
Skilled Nursing/Intermediate Care Facilities (SNF/ICF)	3%	265	31.9	30.5
Other	2%	50	9.8	15.2

*As shown in Table 3, the largest number of deaths (32%) occurred among individuals living in the home of a parent or guardian. This residential setting accounts for three quarters of all individuals served by DDS, including most children and young adults.

THE CASE-MIX ADJUSTED MORTALITY RATE DECREASED BY ALMOST 10% THIS SEMIANNUAL PERIOD COMPARED TO THE SAME PERIOD LAST YEAR.

Case-mix adjustment allows one to monitor risk management by calculating measures that are not influenced by changes in the mix of people served by age, health status, or other risk factors. It accounts for the individual characteristics, including age, residential setting, diagnosis, skills of daily living, behavioral challenges, and history of incidents. Case-mix adjusted trends examine changes in rates keeping the population characteristics the same over time. In doing so, the trend in the adjusted rate is more likely to reflect risk management practices or changes in underlying risks (such as influenza outbreaks). Adjusted rates are calculated for each month and then averaged over the period. The adjusted rate shows what the mortality rate would be if the caseload characteristics were the same over the past several years.

The monthly mortality rate is the average likelihood that an individual will die in a month. As shown in Table 4, the unadjusted average monthly mortality rate is one-sixth of the semiannual rate in Table 1, but expressed in percentages instead of deaths per 1,000. In Table 4, there is a small difference between the adjusted and

unadjusted rate, indicating that individuals currently served by DDS have characteristics that put them at lower risk of mortality than those served in 2014.

The case-mix adjusted mortality rate also declined, from around 0.069% for January-June 2016 to 0.063% this period (see Figure 1). Although this is almost a 10% decline, this change is not statistically significant (meaning it just may reflect normal variation). The adjusted rate this period is about the same as for the last semiannual period.

**Table 4: Semi-Annual and Average Monthly Mortality Rates for Individuals Age 3 and Above
January – June 2017 Compared with January – June 2016**

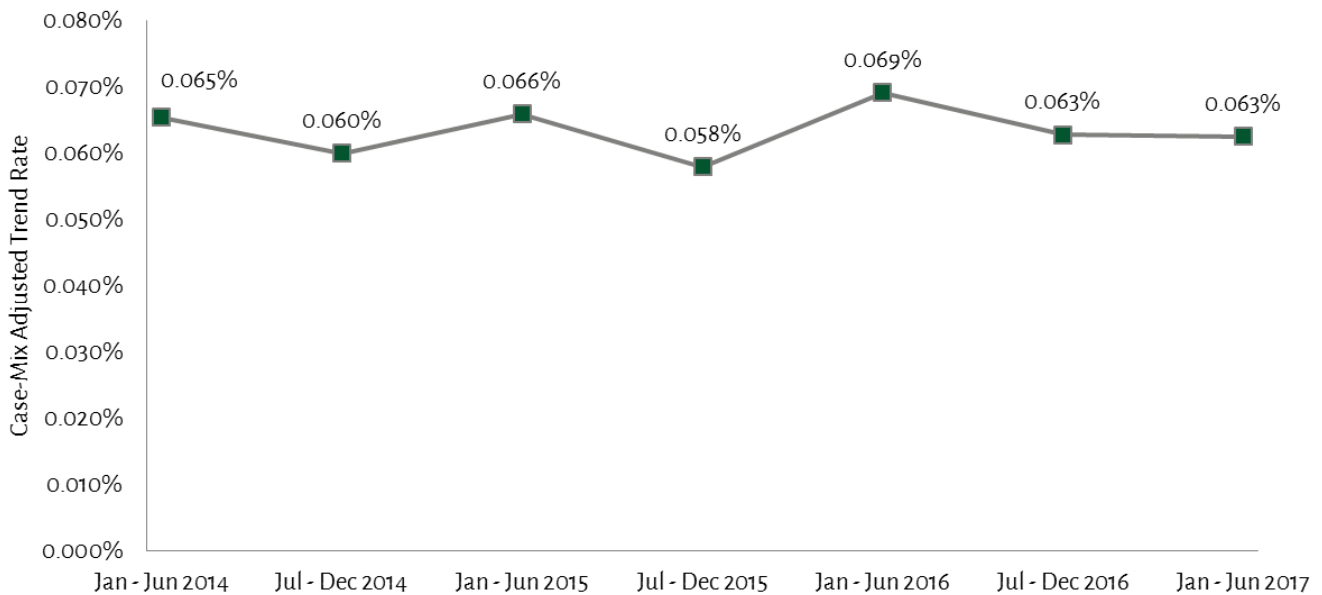
Mortality	January - June 2016	January-June 2017
Deaths per 1,000 Individuals Age 3 and Above	3.75	3.69
Average Unadjusted Monthly Mortality Rate	0.069%	0.062%
Case-Mix Adjusted Mortality Rate	0.069%	0.063%
% Change from Same Period Last Year*		-10%

*Percent change calculated prior to rounding rates.

THE ADJUSTED MORTALITY RATE FOR THIS PERIOD IS LOWER THAN IN THE SAME PERIOD OF THE LAST THREE YEARS.

Figure 1 below shows the monthly average mortality rate in each semiannual period from January-June 2014 to the current period, adjusted for case mix. January-June 2016 had the highest average rate, at 0.069%, following behind the lowest period, July-December 2015, at 0.058%. The rate of 0.063% for the current period is low for the January to June months; the months of December through February tend to have the highest monthly mortality rates. The highest two monthly rates in the period covered by Figure 1 both occurred in calendar year 2016: the adjusted monthly mortality rate was 0.080% in February and December 2016. The high February 2016 rate also drove up the rate for January-June 2016, as seen in the figure.

Figure 1: Average Monthly Mortality Incident Rates by Semiannual Period, Case-Mix Adjusted, January-June 2014 – January-June 2017



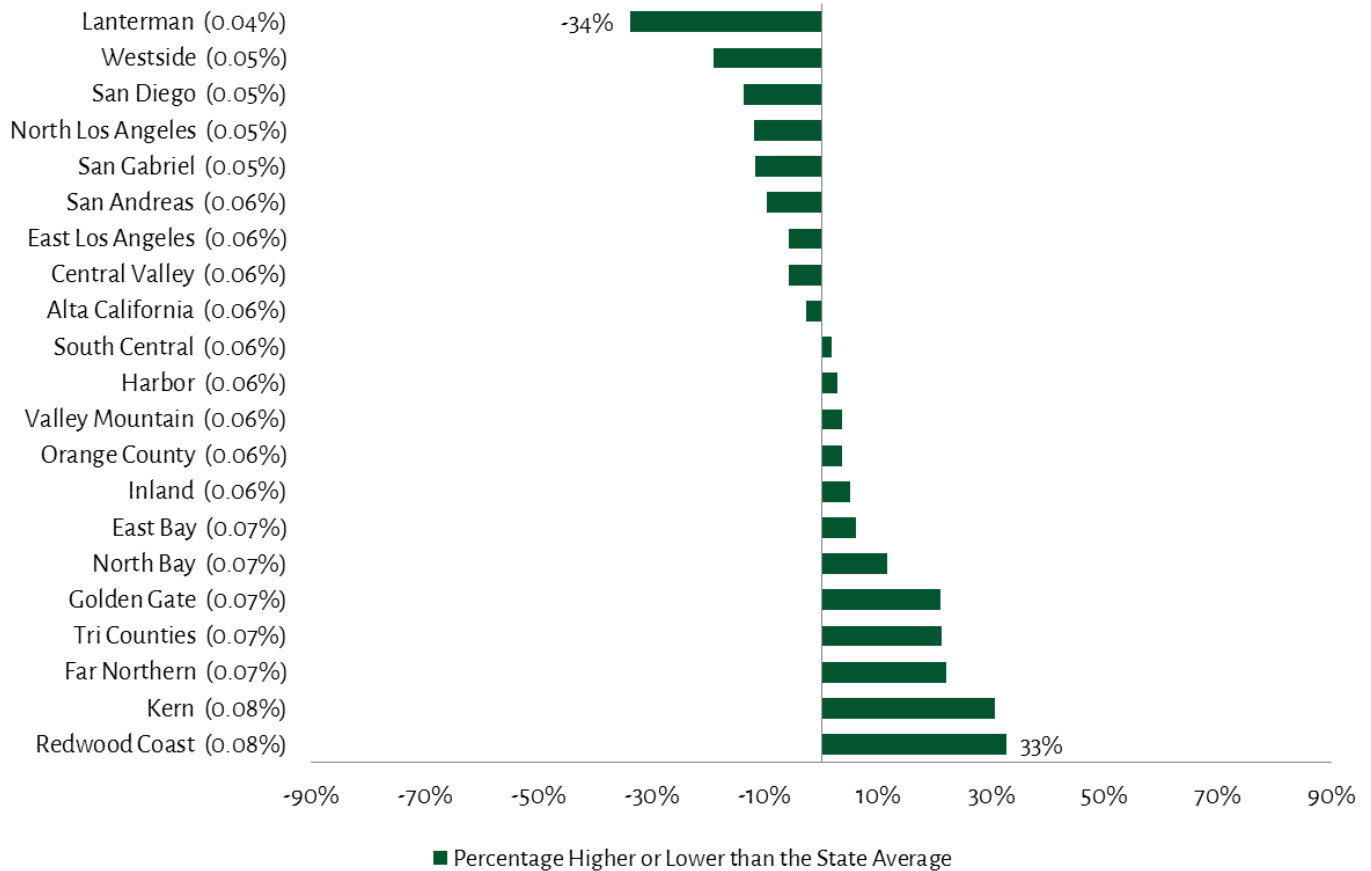
*Values for prior periods may differ from earlier reports due to updated data and adjustment to more recent caseload characteristics.

COMPARED TO PREVIOUS PERIODS, THE RANKING OF REGIONAL CENTERS BY THEIR MORTALITY RATES AND DISTANCE FROM THE STATE AVERAGE HAVE CHANGED.

The bars in Figure 2 represent how much each regional center’s adjusted mortality rate is above or below the statewide rate. For each regional center, the average monthly mortality rate has been adjusted based on the statewide DDS population. Regional centers serving small populations can have substantial month-to-month variation in their mortality rate. Therefore, Figure 2 shows the average differences over the past year (fiscal year 2016-17). The average monthly rates (adjusted for case mix) range from 0.041% at Frank D. Lanterman Regional Center to 0.081% at Redwood Coast Regional Center. With the statewide rate at 0.062% for the year (unadjusted), these translate to a range of 34% below to 33% above the statewide rate.

The rank order of regional centers by adjusted mortality rates can change noticeably from period to period. Of regional centers with the five highest mortality rates in fiscal year 2015-16, only two – Golden Gate Regional Center (GGRC) and Tri-Counties Regional Centers (TCRC) – remain in the top five for the fiscal year 2016-17 (Figure 2). The adjusted mortality rate for GGRC was almost 40% higher than the statewide mortality rate in the previous fiscal year. In this period, the mortality rate at GGRC has improved to 21% above the statewide rate.

Figure 2: Adjusted Mortality Rates by Regional Center, Average Monthly Rate Compared to Statewide Average, July 2016 – June 2017



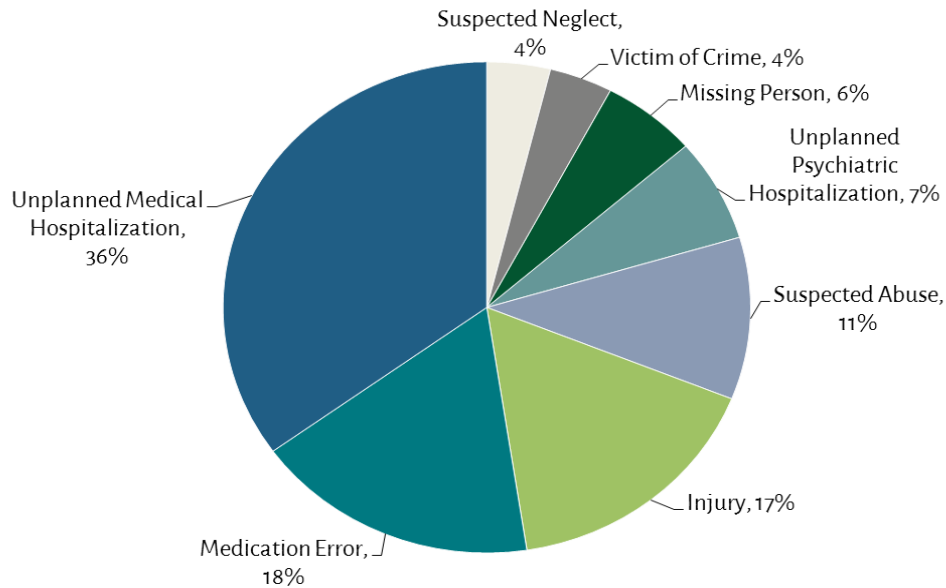
III. NON-MORTALITY INCIDENT FINDINGS

UNPLANNED MEDICAL HOSPITALIZATIONS CONSISTENTLY REPRESENT THE LARGEST SHARE OF NON-MORTALITY INCIDENTS.

The non-mortality SIRs (except victim of crime) are only reportable when they occur under vendored care and, therefore, are rarely reported for individuals who live in the home of a parent or guardian. For that reason, non-mortality SIR rates are monitored primarily for individuals who received vendored residential care. We refer to this group as residing “out-of-home.” Title 17 identifies six major types of non-mortality incidents: unplanned hospitalization, injury, suspected abuse, suspected neglect, missing person and victim of crime. However, the factors that put an individual at risk of an unplanned psychiatric hospitalization differ from the risks for a medical hospitalization. Similarly, risk of medication errors is often quite different from risk of injuries such as fractures or lacerations. Therefore, hospitalizations are divided into medical and psychiatric and injuries into medication errors and other injury. Figure 3 shows how the 9,164 non-mortality incidents between January and June 2017 divided across these incident types.

This period, 36% of non-mortality incidents were unplanned medical hospitalizations. This was a slightly larger share than in the previous two semiannual periods, when unplanned medical hospitalizations accounted for 33-34% of incidents. Medication errors, representing the next highest share of incidents, were a smaller share, 18% instead of 20% in the previous period.

Figure 3: Breakdown of Non-Mortality Special Incidents for Individuals in Out-of-Home Settings, January – June 2017



Values may not sum to 100% due to rounding.

THE INCREASE IN THE NON-MORTALITY INCIDENT RATE IN THE LAST YEAR WAS CONCENTRATED AMONG ADULTS AGE 32 AND OLDER.

The vast majority of individuals in out-of-home settings are adults at least 22 years old. Non-mortality incidents for individuals ages 22 and above accounted for about 94% of the non-mortality SIR count in January – June 2017, and about 92% in January – June 2016. The number of non-mortality SIRs was higher for ages 32 and above in this period compared to the same period last year. The number of non-mortality SIRs per 1,000 out-of-home individuals was higher for all adult age categories this period than in the same period last year, even for young adults ages 22 to 31, though only slightly. Individuals ages 3 to 13 had about 51 non-mortality SIRs per 1,000 individuals this period, 30% less than in the same period last year (73).

Table 5: Non-Mortality Incidents for Out-of-Home Individuals Age 3 and Above, by Age Group, January – June 2017 Compared to January- June 2016

Age in Years	Share of Out-of-Home Individuals Jan-Jun 2017	Number of Non-Mortality SIRs Jan-Jun 2017	SIRs per 1,000 Out-of-Home Individuals Jan-Jun 2017	SIRs per 1,000 Out-of-Home Individuals Jan-Jun 2016
3 to 13	2%	78	51.2	73.2
14 to 21	5%	488	164.7	201.2
22 to 31	18%	1,525	132.3	132.1
32 to 41	19%	1,400	117.9	109.5
42 to 51	19%	1,551	130.5	124.1
52 to 61	21%	2,180	161.8	150.3
62 or older	15%	1,931	198.8	179.1

THE NON-MORTALITY RATE INCREASED ACROSS MOST RESIDENCE TYPES.

Driven in large part by unplanned hospitalizations, individuals in SNF/ICF settings had the highest number of non-mortality incidents per 1,000 population this period (223.5). Only 13% of Individuals in residential care resided in SNF/ICF settings, which care for individuals with significant health care or behavioral needs. Of the 1,856 non-mortality incidents that occurred in these settings, the highest share (60%) were unplanned medical hospitalizations. Nearly half of the unplanned hospitalizations were due to respiratory illness.

Table 6: Non-Mortality Incidents for Individuals Age 3 and Above, by Residence Type, January – June 2017 Compared to January – June 2016

Residence Type	Share of Out-of-Home Individuals Jan-Jun 2017	Number of Non-Mortality SIRs Jan-Jun 2017	SIRs per 1,000 Out-of-Home Individuals Jan-Jun 2017	SIRs per 1,000 Out-of-Home Individuals Jan-Jun 2016
Independent/Supported Living Services (ILS/SLS)	41%	2,548	97.9	89.8
Community Care Facilities (CCF)	37%	4,182	177.6	170.1
Skilled Nursing/Intermediate Care Facilities (SNF/ICF)	13%	1,856	223.5	211.6
Other	8%	567	111.4	122.5

At 178 incidents per 1,000 individuals in CCF settings, SIRs occurred more often for CCF residents this period compared to last period (July 2016 – December 2016), during which there were 159 incidents per 1,000 individuals. Although unplanned hospitalizations were also the most common type of incident for CCF residents, hospitalizations represented a smaller share of SIRs for CCFs. Of the non-mortality incidents in the CCF residence type, about 33% were unplanned hospitalizations – nearly half the share of this incident type for SNF/ICF. Almost 20% of the 4,182 non-mortality incidents in CCF settings were injuries, while 17% were suspected abuse or neglect incidents.

THE CASE-MIX ADJUSTED NON-MORTALITY RATE INCREASED BY 3.3% COMPARED TO THE SAME SEMIANNUAL PERIOD LAST YEAR.

As with mortality incidents, characteristics such as age, residential setting, skills of daily living and behavioral challenges help predict the likelihood of a non-mortality incident. For example, an individual with very limited mobility may be at higher risk for suspected neglect, while an individual with behavioral challenges may be at higher risk of injury or missing person. In addition, some individuals have multiple incidents. This is especially true for unplanned hospitalizations, psychiatric admissions and missing person incidents. Thus, the number of people with incidents is lower than the number of incidents, although these two measures are more similar in a shorter window of time.

Similar to the mortality rate, the case-mix adjustment in this report uses the characteristics of out-of-home individuals observed at the end of fiscal year 2014-15. That is, the adjusted rate tells us what the non-mortality rate would be if out-of-home individuals this period had the same characteristics as in June 2015.

Table 7 reports the unadjusted and adjusted monthly non-mortality incident rates, averaged over the six-month period.

Table 7: Non-Mortality Incident Rates for Out-of-Home Individuals, January – June 2017

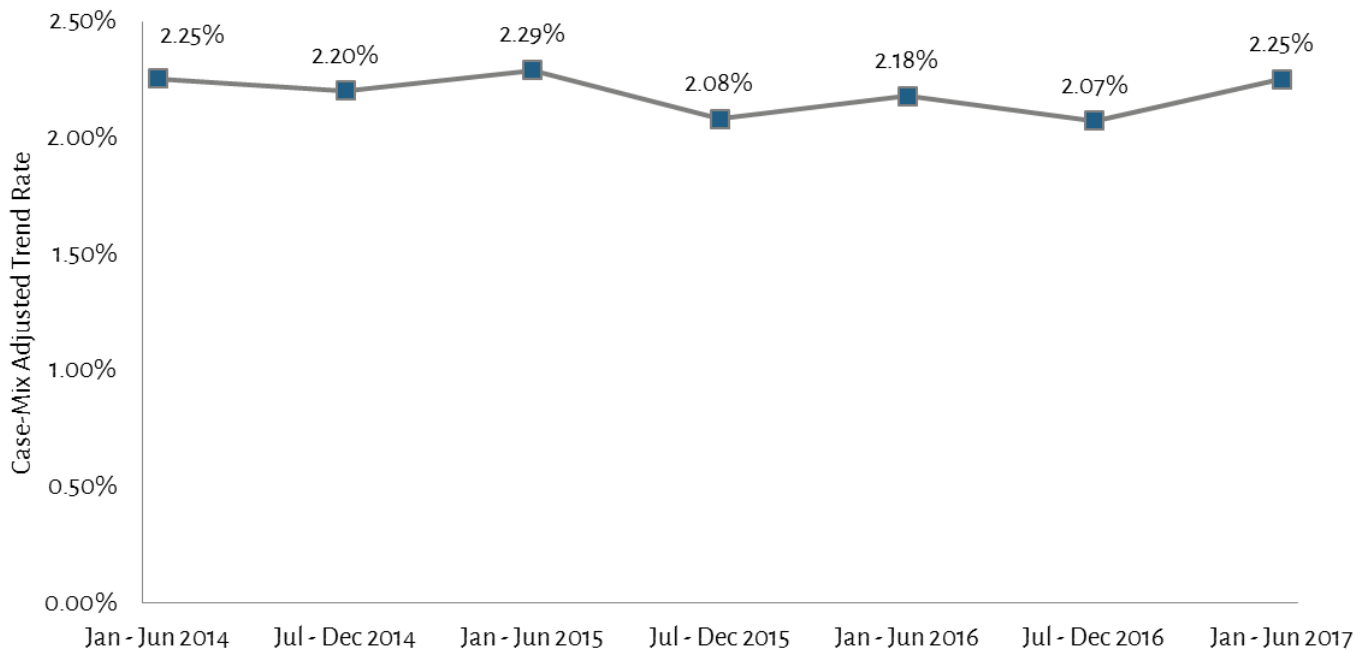
Non-Mortality	January-June 2016	January-June 2017
Non-Mortality Incidents per 1,000 Individuals Age 3 and Above	139.1	145.4
Average Unadjusted Monthly Non-Mortality Rate	2.14%	2.22%
Case-Mix Adjusted Non-Mortality Rate	2.18%	2.25%
% Change from Same Period Last Year		+3.3%

The case-mix adjusted rate increased by 3.3% compared to the same period last year, but this change is not statistically significant. The case-mix adjusted non-mortality rate this semiannual period increased by about 8.7% compared to the last semi-annual period, going from 2.07% to 2.25%. This is a statistically significant change, meaning it is a higher increase than we would expect from typical variation.

THE NON-MORTALITY RATE INCREASED THIS PERIOD, RETURNING TO A LEVEL SEEN TWO YEARS AGO.

Figure 4 shows the monthly average non-mortality rate in each semiannual period from January-June 2014 to the current period, adjusted for case mix. In the July-December 2016 period, the case-mix adjusted non-mortality rate was the lowest it has been over the last several years, at 2.07%. Non-mortality rates have generally been higher from January-June than in July-December, but last year was unusually low for the January-June period. In this period, the monthly rates that contribute to the 2.25% average reflected a typical January-March quarter (when rates are often highest for the year), but the rate did not then drop down in the April-June quarter.

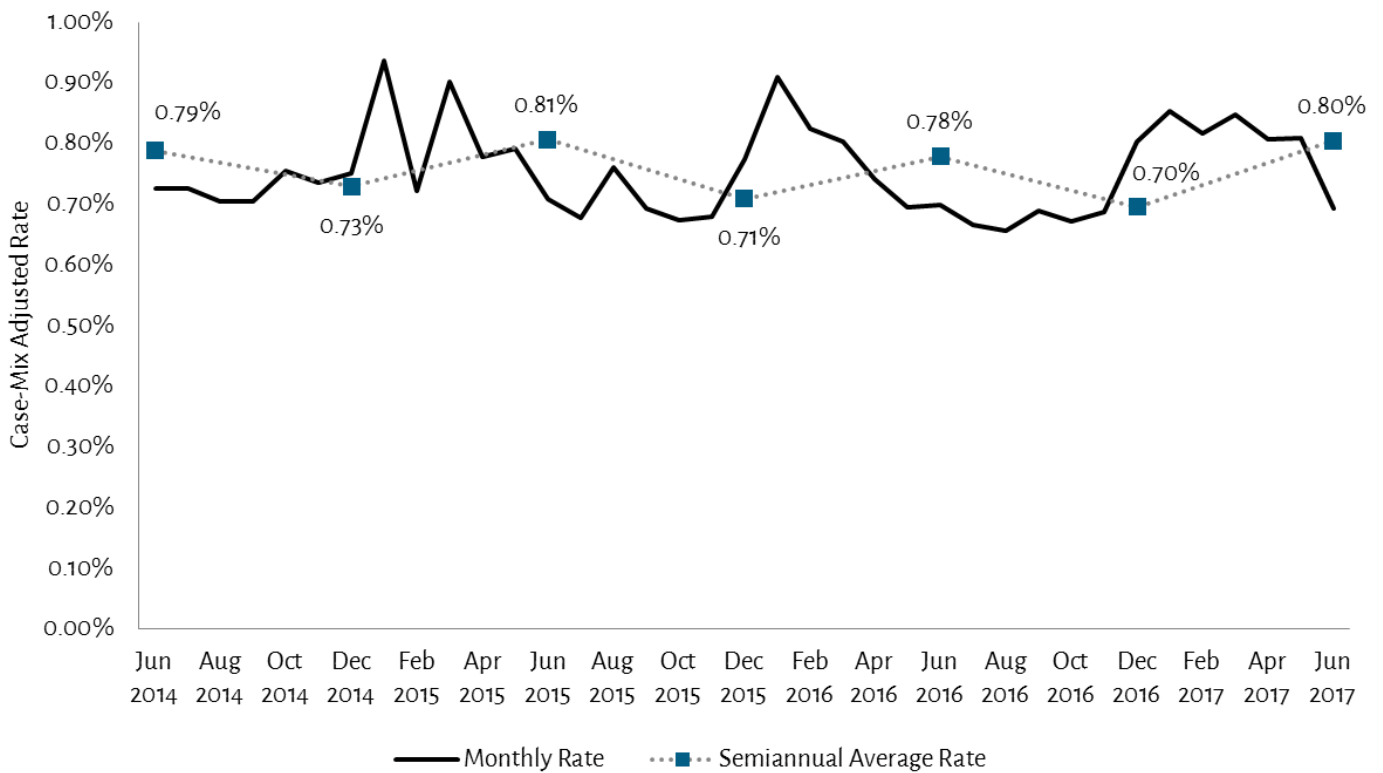
Figure 4: Non-Mortality Incidents, Statewide Case-Mix Adjusted Semiannual Trend, January 2014 – June 2017



THE INCREASE THIS PERIOD IS LARGELY EXPLAINED BY UNPLANNED HOSPITALIZATIONS, DUE TO RESPIRATORY ILLNESS AND INFECTION.

For the January-June 2017 period, the case-mix adjusted unplanned hospitalization rate was 0.80%, compared to the rate of 0.70% for the July-December 2016 period. In 2016, the monthly case-mix adjusted unplanned hospitalization rate peaked at 0.91% (January 2016), and then declined. However, this year, the unplanned hospitalization rate rose to a peak by January 2017 (0.85%), but did not decline until April 2017 (0.81%). The rate of unplanned hospitalizations due to respiratory illness drove the rise in late 2016, peaking at 0.38% in January 2017 before declining. The monthly rate of unplanned hospitalizations due to infection stayed relatively constant around 0.30% in late 2016, but rose to 0.33% in January 2017, declining only in June 2017 to about 0.27%.

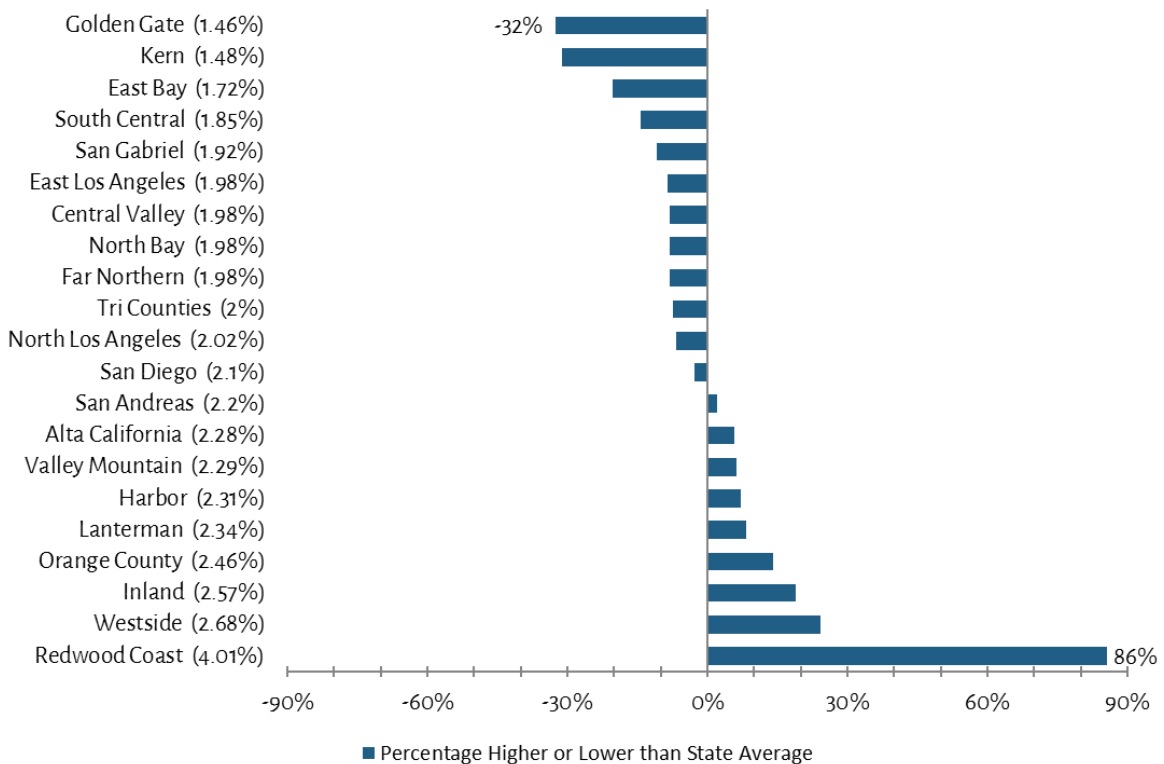
Figure 5: Unplanned Medical Hospitalization Incidents, Statewide Case-Mix Adjusted Rates, June 2014 – June 2017



FOR 20 OUT OF 21 REGIONAL CENTERS, THE AVERAGE NON-MORTALITY INCIDENT RATE FOR JULY 2016 TO JUNE 2017 WAS WITHIN 32% OF THE STATE AVERAGE.

Like Figure 2, Figure 6 applies case-mix adjustment to compare non-mortality rates across regional centers, subtracting the effects of differences in the ages and needs of the populations they serve. The bars in Figure 6 represent how much each regional center's adjusted non-mortality rate is above or below the statewide rate. For each regional center, the average monthly rate has been adjusted based on the statewide DDS population. In light of the variation in rates for small regional centers, the figure shows the average differences over the past year (fiscal year 2016-17). Most regional centers are in a fairly close range, about 25% above or below the statewide average incident rate of 2.16% per month. Golden Gate and Kern Regional Centers are 31-32% below the average, which may reflect differences in reporting.

Figure 6: Adjusted Non-Mortality Rates by Regional Center, Average Monthly Rate Compared to Statewide Average, July 2016 – June 2017



Redwood Coast Regional Center (RCRC) had an average monthly non-mortality incident rate 86% higher than the statewide average, at 4.01%. For the year ending June 2016, for example, RCRC was 60% above the statewide average. Controlling for observable differences in the characteristics of its caseload, RCRC has the highest rate of medication errors, suspected abuse, suspected neglect and victim of crime incidents among the 21 regional centers. It is also near the top in unplanned hospitalizations. The regional center has a larger share of its population in SLS care, rather than group settings such as CCFs. SLS settings offer individuals more autonomy, but can open up the individuals to more risk.



DDS, through Mission, is coordinating closely with the regional centers to track and monitor the follow-up activities associated with quarterly SIR spikes. For longer-term increases in incident rates, Mission uses SIR case reviews, site visits, and statistical analyses as part of its monitoring, discovery, and improvement activities. A number of additional activities continue to support DDS and regional centers in preventing future incidents. These activities are described on the following page.

IV. RISK MANAGEMENT EFFORTS

MONITORING AND DISCOVERY ACTIVITIES

Reporting Back: Regional centers with quarterly spikes in individual incident types report back to DDS, through Mission, any discovery and remediation activities related to these spikes, including a description of why any spikes occurred, what follow-up actions were taken, and whether the centers faced obstacles in implementing these follow-up activities. These responses are provided to the DDS Quality Management Executive Committee and may be used to develop strategies for how to mitigate risk to individuals statewide.

Long-Term Increases in Incident Rates: Mission has a multi-stage process to investigate long-term increases in incident rates. Mission provides additional analyses and technical assistance to regional centers identified based on results such as those shown on page 9. For identified regional centers, additional analyses are conducted to determine the detailed incident types and/or individual characteristics associated with the increase. Based on these results, Mission determines whether a more detailed review of the SIRs is necessary to better understand the issue. As appropriate, Mission also works with the regional centers to identify mitigation strategies. Activities this period included:

- Mission provided data analysis and technical assistance to GGRC regarding its mortality incidents rates. During the technical assistance, it was found that GGRC may have been under-reporting non-mortality incidents including unplanned hospitalizations. This affects the case-mix adjustment for mortality rates. In response to findings Mission presented, GGRC has taken steps to make certain that it reports CDER and SIR data as completely and as accurately as feasible. The rate of mortalities at GGRC seems to be decreasing.
- Mission established that the increase in medication errors accounted for the difference between RCRC's non-mortality incident rate and the statewide average. Mission has continued to conduct follow-up analyses every six months of medication errors at RCRC. RCRC implemented the Medication Error Diagnostic Tool to limit medication errors in its SLS population. Mission analyzes the completed tools on a quarterly basis and will continue to provide support to RCRC in implementation of this and other mitigation strategies.
- Mission continues to work with RCRC regarding its suspected abuse incidents. After analyzing the suspected abuse data for RCRC and the rest of the state, Mission concluded that the overall rate of suspected abuse at RCRC would decrease substantially if RCRC focused on individuals with repeated suspected abuse incidents. Mission and DDS attended an in-person meeting with RCRC to review data and discuss mitigation strategies. RCRC is in the process of taking the following steps to reduce suspected abuse incidents: offer a crisis service to individuals as appropriate to develop healthy relationships, impose immediate danger sanctions with providers who submit a report that will immediately remove the staff from working with individuals until the staff is cleared by law enforcement or Adult Protective Services, provide increased case management and contact each individual who has a report of suspected abuse, provide technical assistance to each vendor, and have the RCRC Wellness Nurse provide technical assistance to make sure the individual receives proper medical care.



SYSTEM IMPROVEMENT ACTIVITIES

DDS SafetyNet Website: Mission maintains the DDS SafetyNet, a website promoting health and safety for individuals with developmental disabilities. In addition to addressing safety issues identified in partnership with the Association of Regional Center Agencies' Chief Counselor Risk Management Committee, SafetyNet materials respond directly to trends in special incident rates to help manage risk among the individual population. In this semiannual period, DDS published spring content focused on fall prevention to address injury incidents.

DDS Mental Health Services Act (MHSA): Cycle III (Fiscal Year 2014/15 to 2016/17) MHSA Projects are in their third year. A Mental Health/Forensic Collaborative will assist individuals and regional centers in navigating the criminal justice system and shortening incarceration time by establishing competency to stand trial training and identifying resources within the community. An infant mental health project will promote cultural competence in clinical care settings, while another project will develop a mental health clinic to provide psychiatric assessment, medication management, and individual and group therapy. Two projects will assist transition age youth with referrals and connections to appropriate community resources, continuity of care before, during and after hospital admission, identify new community resources, early detection and assessment of mental health conditions and establish a Wellness/Drop-In Center. The final project will provide training on evidence-based practices and how each can be used for prevention and early intervention.

V. APPENDIX

SPECIAL INCIDENT DEFINITIONS

Injury – Serious injury/accident, including lacerations requiring sutures or staples; puncture wounds requiring medical treatment beyond first aid; fractures; dislocations; bites that break the skin and require medical treatment beyond first aid; internal bleeding requiring medical treatment beyond first aid; any medication errors; medication reactions that require medical treatment beyond first aid; or burns that require medical treatment beyond first aid.

Medication error – When an individual under vendored care experiences one or more of the following situations: 1) wrong medication, 2) wrong client, 3) wrong dose, 4) wrong time, 5) wrong route. For example, an individual has a one-hour window to take his or her medications based on the time prescribed by the physician. Any medication administered or self-administered more than one hour before or after the prescribed time is considered a missed dose and, therefore, a “wrong time” medication error.

Missing person – These conditions must apply: the vendor has communicated with any law enforcement agency in any way and described the individual as missing to that agency or has filed a formal missing person’s report with a law enforcement agency.

Mortality – Any individual death, regardless of cause.

Suspected abuse – All vendors shall report to the regional center the following special incidents if they occurred during the time the individuals was receiving services and supports from any vendor or long-term health care facility: Reasonably suspected abuse/exploitation, including physical, sexual, fiduciary, emotional/mental, or physical and/or chemical restraint.

Suspected neglect – Reasonably suspected neglect, including failure to provide medical care for physical and mental health needs; prevent malnutrition or dehydration; protect from health and safety hazards; or assist in personal hygiene or the provision of food, clothing, or shelter, or exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.

Unplanned medical hospitalization – Unplanned hospitalization due to the following conditions: respiratory illness, including but not limited to asthma, tuberculosis, and chronic obstructive pulmonary disease; seizure-related; cardiac-related, including but not limited to congestive heart failure, hypertension, and angina; internal infections, including but not limited to ear, nose and throat, gastrointestinal, kidney, dental, pelvic, or urinary tract; diabetes, including diabetes-related complications; wound/skin care, including but not limited to cellulitis and decubitus; and nutritional deficiencies, including but not limited to anemia and dehydration.

Unplanned psychiatric hospitalization – Unplanned or unscheduled hospitalization due to a psychiatric condition. An involuntary psychiatric hospitalization accomplished pursuant to Section 6500 of the Welfare and Institutions Code is reportable to DDS when all of the following conditions are met: The discharge diagnosis indicates that the individual was admitted to hospital for a psychiatric condition, the individual is not conserved and does not consent to the admission, or the individual is conserved and the individual’s parent, legal guardian or conservator does not consent to the admission, and the legal mechanism used to accomplish the admission is section 6500.

Victim of crime – Includes the following: robbery, including theft using a firearm, knife, or cutting instrument or other dangerous weapons or methods that force or threaten a victim; aggravated assault, including a physical attack on a victim using hands, fists, feet, or a firearm, knife, or cutting instrument, or other dangerous weapon; larceny, including the unlawful taking, carrying, leading, or riding away of property, except for motor vehicles, from the possession or constructive possession of another person; burglary, including forcible entry; unlawful non-forcible entry, and attempted forcible entry to a structure to commit a felony or theft therein; and rape, including rape and attempts to commit rape.