Risk Management
Year in Review Annual Report
Fiscal Year 2018-19

Submitted to California Department of Developmental Services

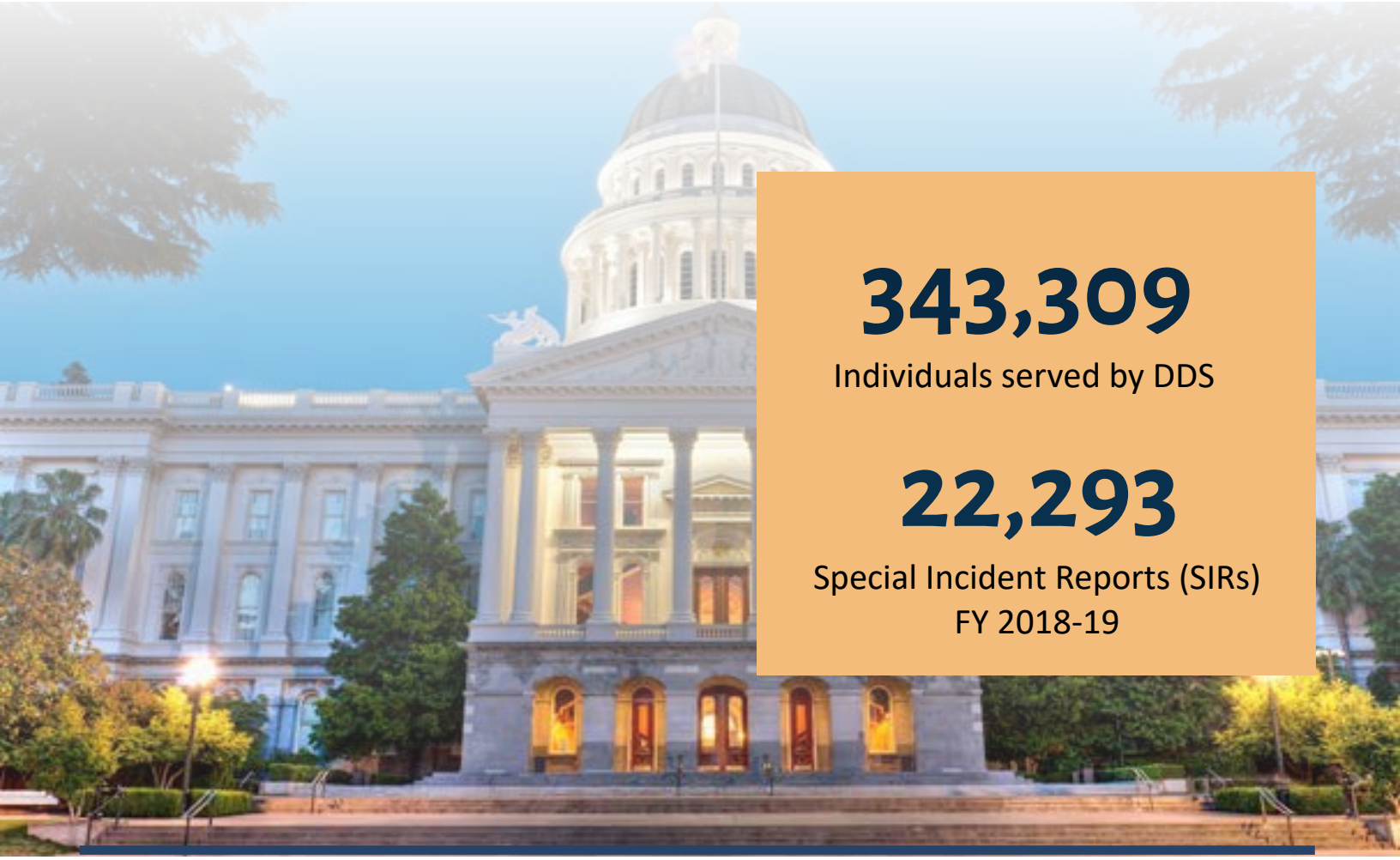
Prepared by Mission Analytics Group, Inc.

February 2020

About this Report

This year-end report summarizes the rates of reported adverse events that occurred to Californians with intellectual and developmental disabilities (I/DD) during the fiscal year (FY) 2018-19. The California Department of Developmental Services (DDS) relies on a network of 21 regional centers to plan, coordinate, and monitor an array of services and supports for individuals with I/DD, including coordinating the reporting of and response to "special incidents." As part of the risk management system, DDS monitors the occurrence of special incidents to identify trends and assists regional centers in developing strategies for preventing and mitigating risks.

Categories of reportable special incidents are defined by Title 17 of the California Code of Regulations. These include suspected abuse, suspected neglect, injury requiring medical attention, unplanned hospitalization, and missing person if any of these incidents occur when an individual is receiving services in a long-term health facility or funded by a regional center (under vendored care). In addition, any occurrence of mortality or an individual being a victim of crime must be reported. A Special Incident Report (SIR) on a given event may be reported under multiple categories. For example, an injury requiring medical attention that arises from failure to protect an individual from a safety hazard may be reported as both injury and suspected neglect.



343,309

Individuals served by DDS

22,293

Special Incident Reports (SIRs)
FY 2018-19

Regional centers reported 22,593 incidents to DDS in FY 2018-19.

California's 21 regional centers served more than 340,000 individuals in the community in FY 2018-19. During FY 2018-19, vendors, long-term care facilities, regional centers and other reporters submitted 22,593 special incident reports (SIRs). Compared to FY 2014-15, the number of individuals served has increased 21%. This reflects growth in primary school-age children and young adults. See DDS Fact Book for additional information. However, the number of reported incidents in FY 2018-19 was only 3% higher than in FY 2014-15. See next page for the rate of incidents for individuals served.

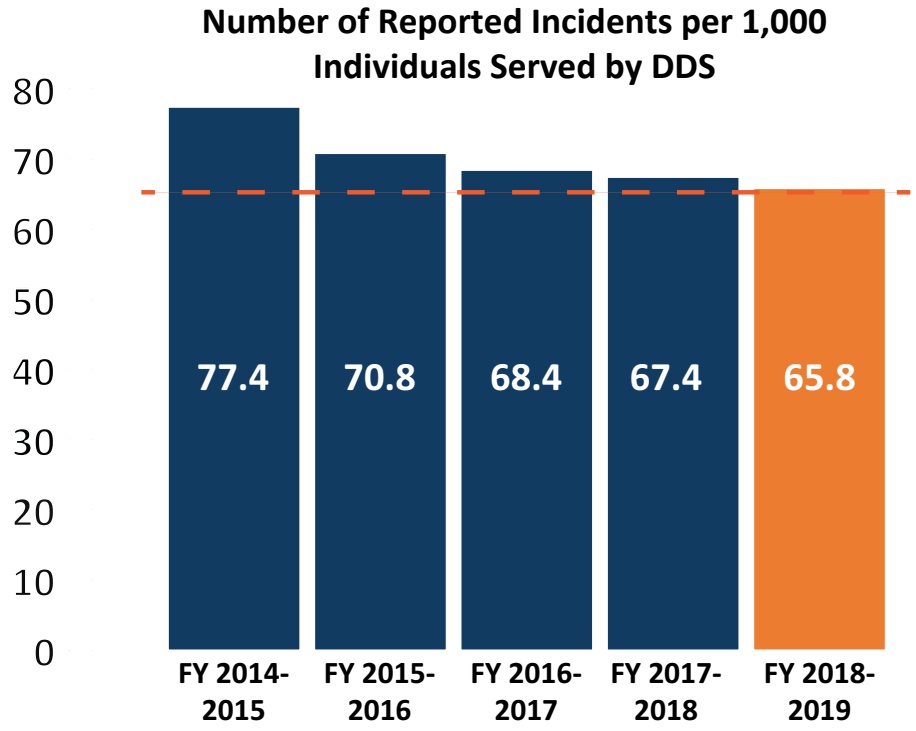
	Individuals Served by DDS	Reported Incidents
FY 2014-15	284,196	22,006
FY 2015-16	297,333	21,039
FY 2016-17	311,679	21,320
FY 2017-18	326,162	21,977
FY 2018-19	343,309	22,593

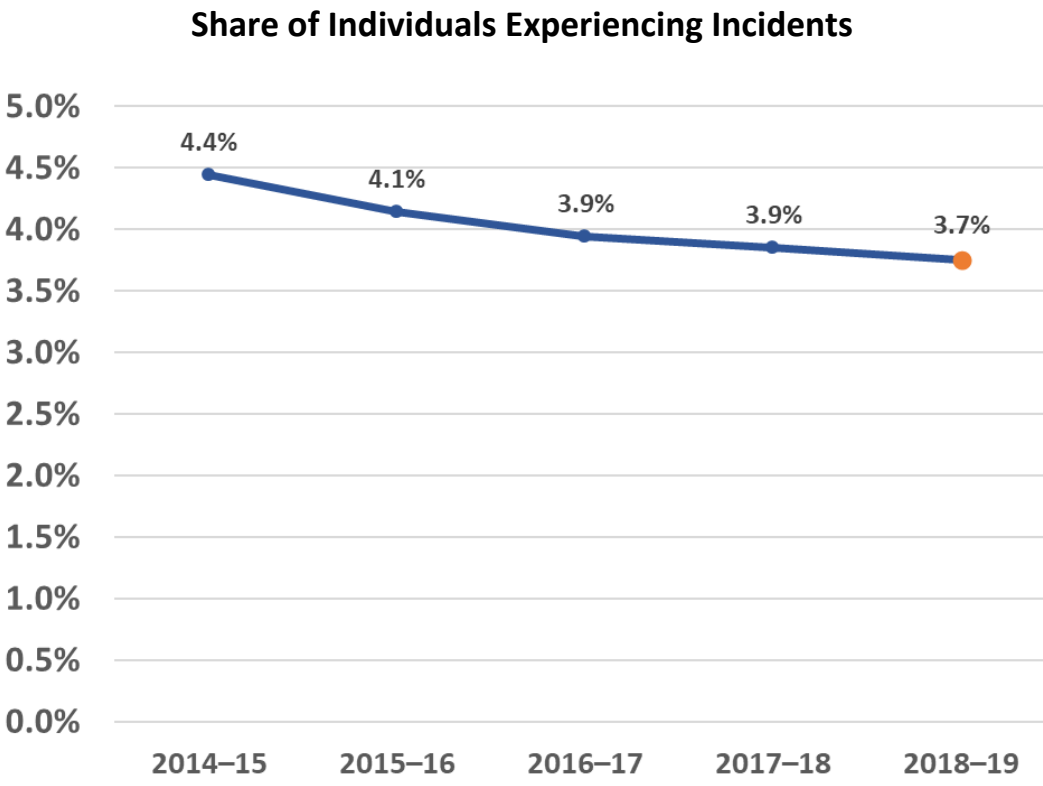
The number of individuals served has increased by **21%**

The number of SIRs has increased by **3%**

The number of reported incidents per 1,000 individuals served has fallen over the last five years.

To compare incident rates over time, the number of incidents per 1,000 individuals served by DDS was calculated. In FY 2018-19, there were 65.8 reported incidents for every 1,000 individuals served. This rate fell in each of the past five years. The decline is statistically significant. The share of individuals experiencing incidents has also decreased over the last five years.

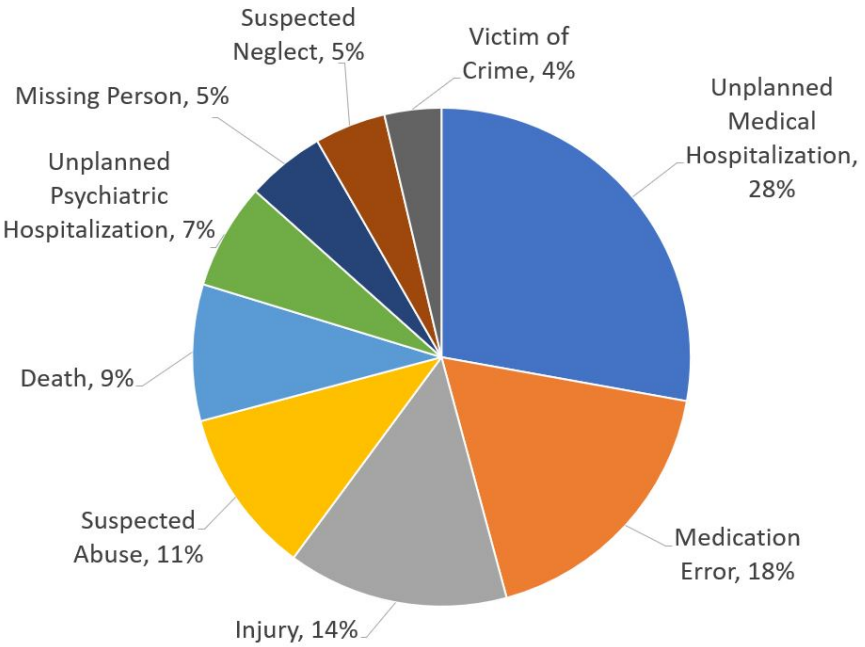




Unplanned medical hospitalizations and medication errors are the most common types of reported incidents.

Deaths accounted for 9% of reported incidents in FY 2018-19. The remaining 20,553 (91%) "non-mortality" incidents can be grouped into eight major categories. Unplanned medical hospitalizations resulted in 6,440 reported incidents this fiscal year, representing 28% of all reported incidents and the most commonly reported incident type. Medication errors were reported in 4,158 SIRs (18%). Victim of crime, suspected neglect and missing person incidents are the least commonly reported incident types. See page 7 for more information.

Breakdown of Reported Incidents by Type



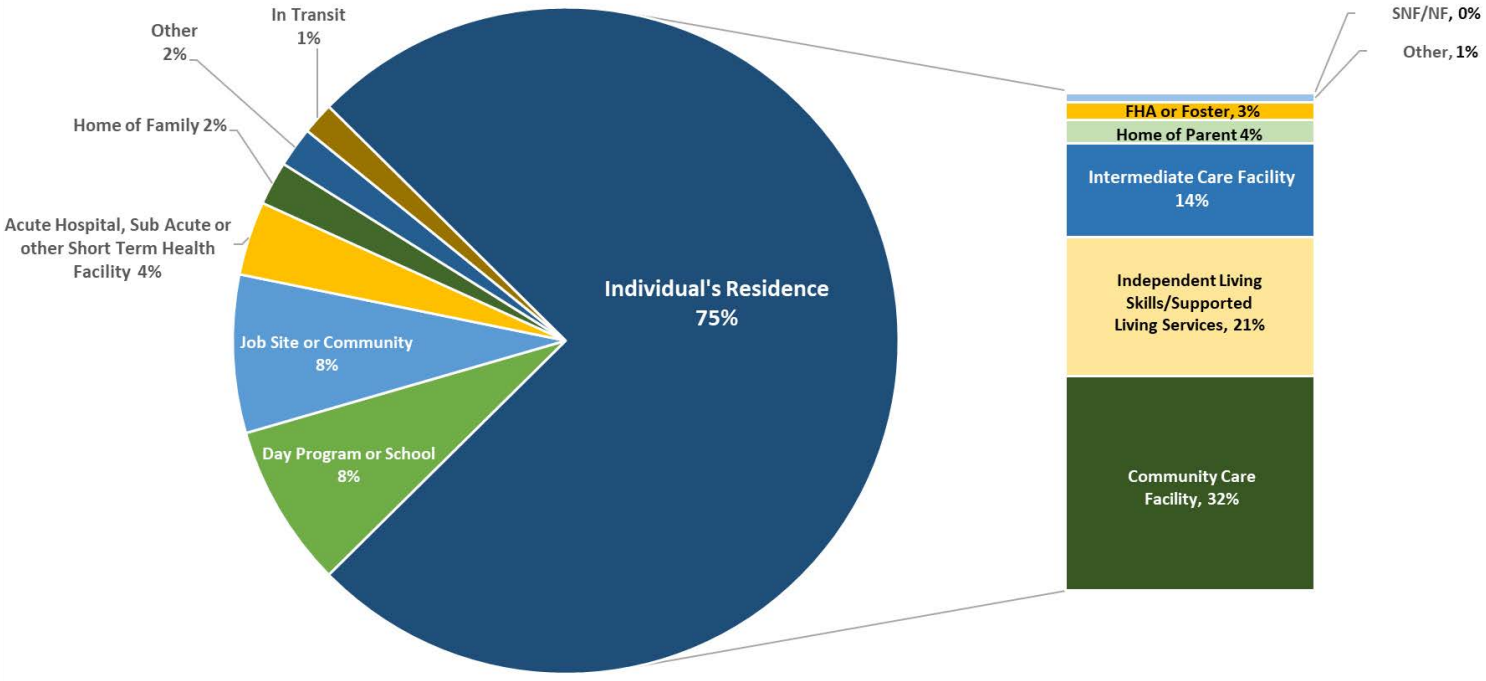
Top 3 Reported Incidents in FY 18-19 and Percentage Increase from FY 17-18

Unplanned medical hospitalizations (3%)
Medication error (8%)
Injury (<1%)

Most non-mortality incidents occur in the individual's home.

Non-mortality incidents are reportable to DDS if they occur in a long-term care or residential facility or under vendored care, such as supported living services. As a result, most non-mortality incidents are reported for individuals who live in residential care settings, rather than in the home of a parent or guardian. Three quarters of reported non-mortality incidents occurred in the individual's residence. About one sixth of reported incidents occurred either in day programs/schools or at job sites or in the community.

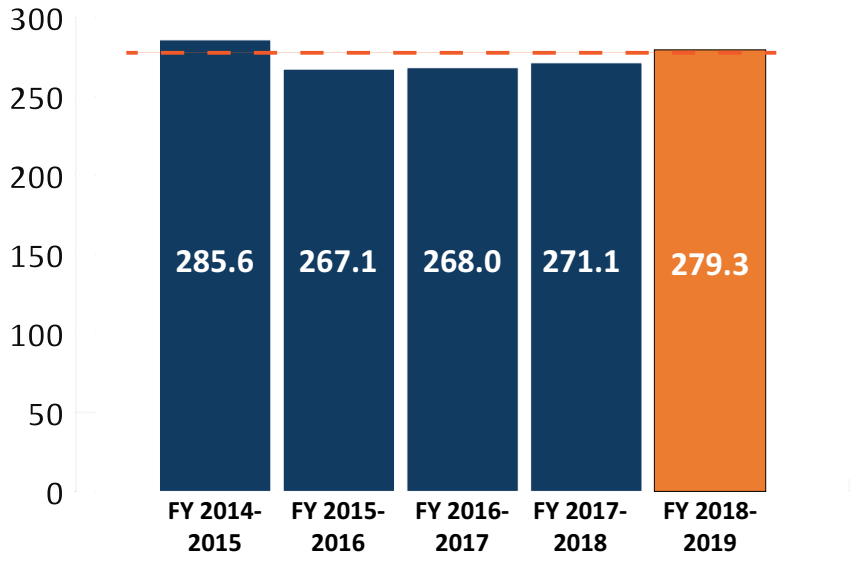
Location of Non-Mortality Incidents



The rate of non-mortality incidents rose among individuals who reside outside the home of a parent or guardian.

Because of Title 17 reporting requirements, 95% of all reported incidents are reported for individuals who reside outside the home of a parent or guardian. By the end of FY 2018-19, 67,004 individuals served by DDS resided outside the home of a parent or guardian. The number of reported incidents per 1,000 individuals was higher in FY 2018-19 than it has been in recent years, although lower than it was in FY 2014-15.

Non-Mortality Reported Incidents per 1,000 Individuals Who Reside Outside the Home of a Parent or Guardian



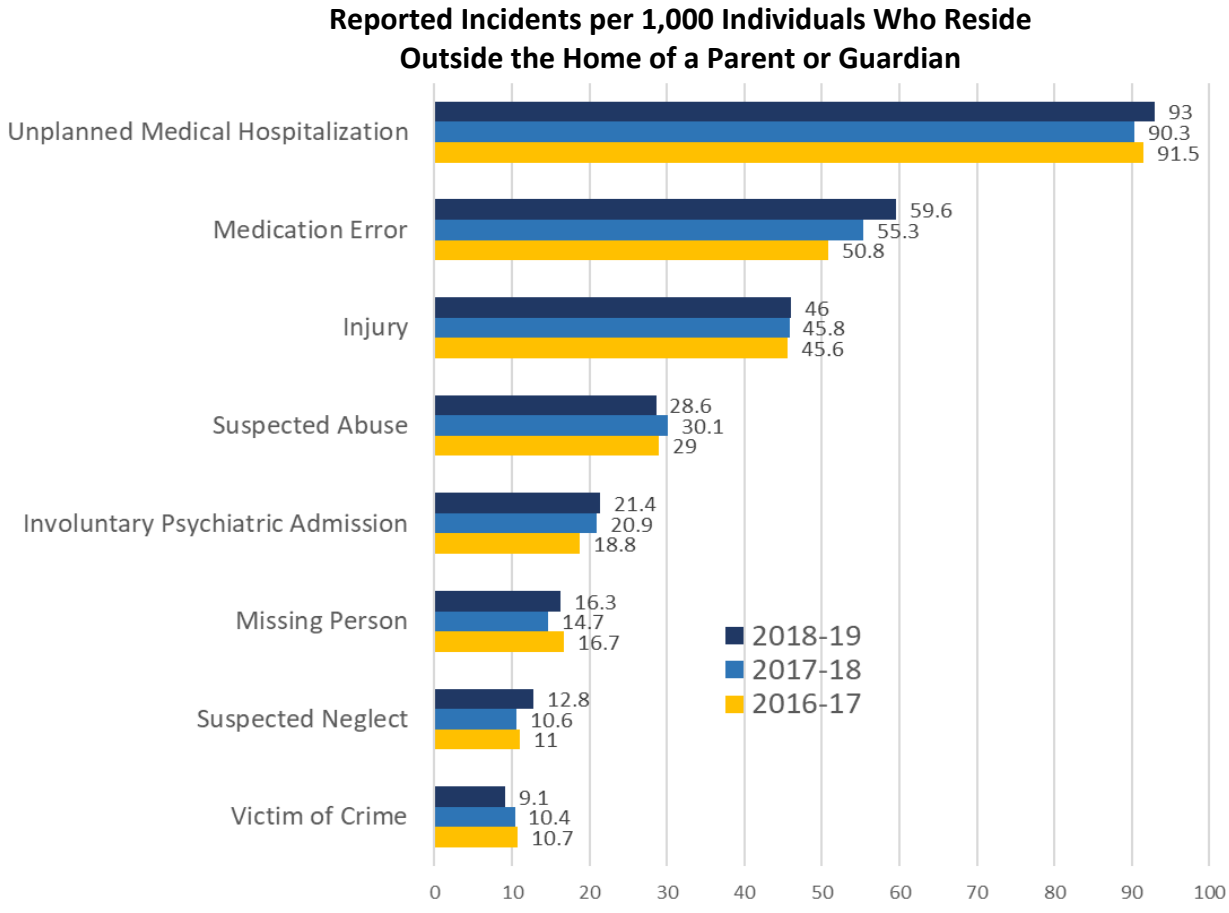
67,004

Individuals served by DDS reside outside the home of a parent or guardian and represents about 20% of all the individuals served. The number of individuals that reside outside the home of a parent or guardian has increased by **5%** since FY 2015-2016.

Higher rates of unplanned medical hospitalization and medication error incidents account for most of the increase in reported non-mortality incidents.

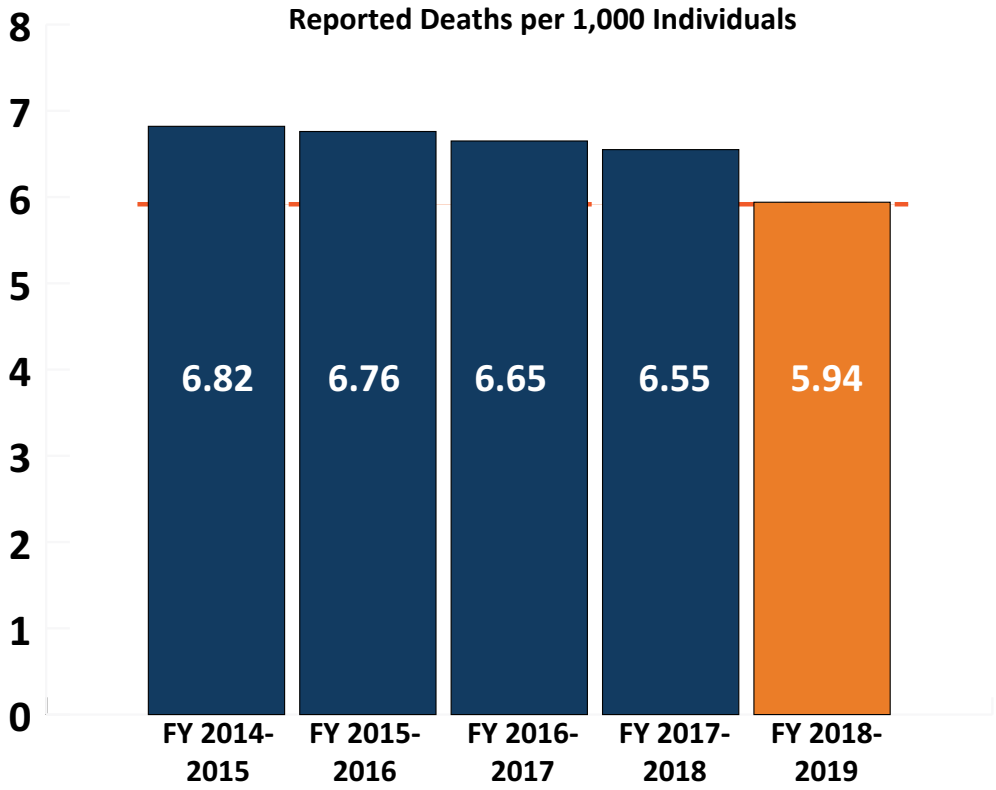
The largest percentage increases in reported incident rates occurred for suspected neglect (up 21%) and missing person incidents (up 11%). The percentage of unplanned medical hospitalization and medication error reported incidents also increased. However, it is of note that these incident types are more common and thus a small percentage increase in those rates represent a larger number of reported incidents than the increase in suspected neglect and missing person incidents. In addition to reviewing each incident report, DDS and the regional centers responsible for case management conduct additional review of upward trends in reported incidents.

Regional centers with persistently high trends were asked to report back to DDS on remediation and improvement activities. Some regional centers provided additional training to vendors, case managers and service coordinators on establishing protocols for illness prevention, monitoring of vulnerable individuals, increased case management, and better incident reporting tools. Ongoing activities to better understand unplanned medical hospitalization causes are being pursued in conjunction with regional center medical doctors while medication errors are being addressed via the diagnostic tool provided to the regional centers. Comprehensive analysis of rates and technical assistance relating to suspected neglect and unplanned hospitalization continues to be provided to the regional centers to enhance their prevention, remediation, and mitigation strategies.



The number of deaths per 1,000 individuals was lower than in previous years.

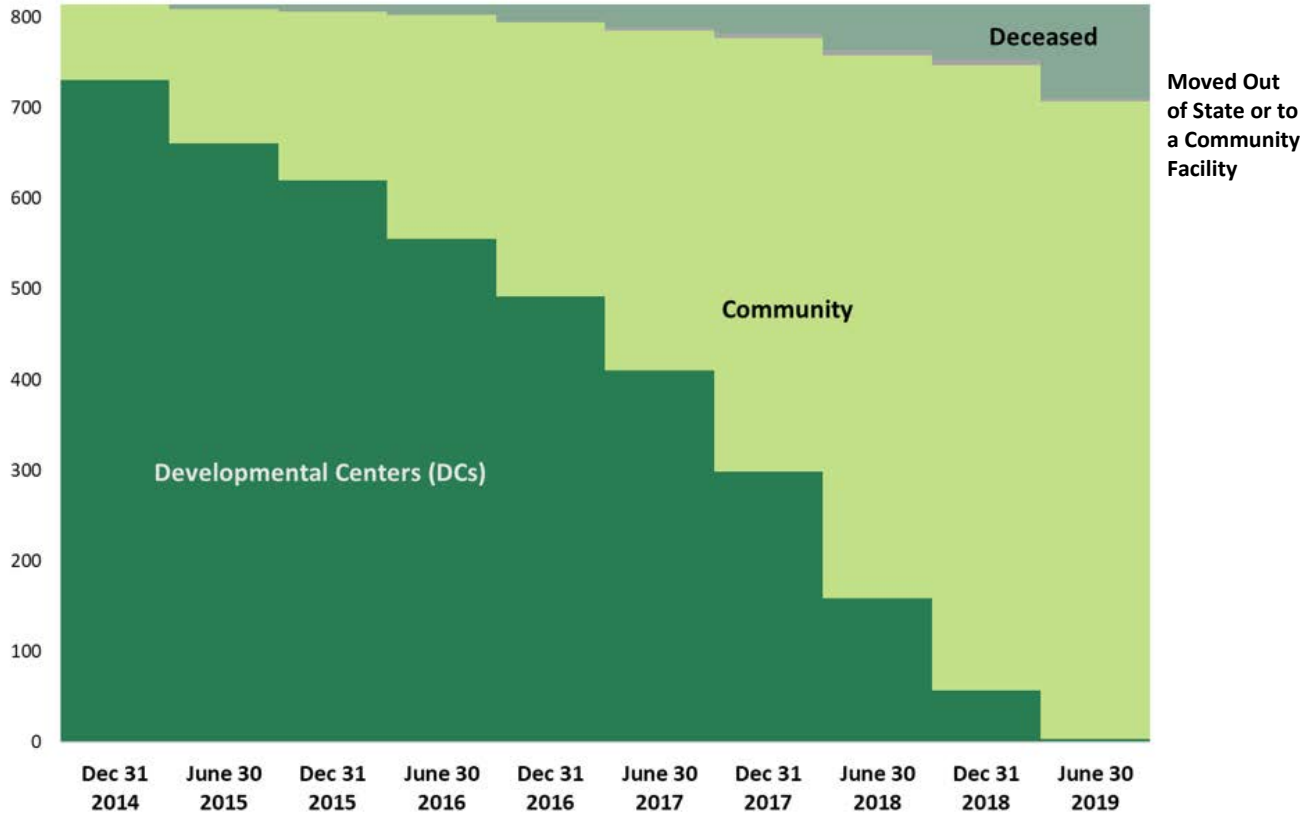
There were 2,040 deaths reported in FY 2018-19 compared to 2,136 reported the previous year. The number of deaths per 1,000 individuals fell from 6.55 in FY 2017-18 to 5.94 in FY 2018-19, a 9% decline. This rate has trended down over the last five years. This year's decline is statistically significant.



By June 30, 2019, almost all developmental center (DC) residents had transitioned into community settings.

The May 2015 Revision to the Governor's Budget called for the closure of Sonoma Developmental Center (SDC), Fairview Developmental Center (FDC), and the General Treatment Area of Porterville Developmental Center (PDC). The last resident moved out of SDC in December 2018. Out of 886 individuals who resided in these DCs in May 2015, only 92 were still residing at FDC or PDC at the end of FY 2018-19.

DC Residents Transition to Community Settings



California Department of Developmental Services: "Fairview Developmental Center"

Most individuals who moved from the DCs reside in small, specialized residential facilities.

Among the 618 individuals residing in the community at the end of FY 2018-19, 85% of people lived in residential settings designed to meet the needs of former DC individuals. This total includes the 54% who lived in specialized residential facilities, 25% who lived in Adult Residential Facilities for Persons with Specialized Health Needs (ARFPSHN), and 6% who lived in Enhanced Behavioral Support Homes (EBSH). All of these residence types serve six or fewer individuals. The rest of the cohort resided in the same types of residential settings as those served by regional centers more broadly, including community care facilities, supported living, and intermediate care facilities.

Residence Types of Movers in the Community on June 30, 2019