Critical Incident Reporting

2016

Trend Analysis

Prepared by the Critical Incident Reporting Team

Division of Developmental Disabilities
Department of Human Services
Hillsview Plaza, E. Hwy 34
c/o 500 East Capitol
Pierre, SD 57501-5070

Phone: (605) 773-3438
FAX: (605) 773-7562
E-Mail: infodd@state.sd.us

TABLE OF CONTENTS:

New!

The eleventh annual Critical Incident Report (CIR) Trend Analysis provides a summary review of the data submitted by seventeen Community Support Providers (CSPs), two Service Providers (SPs), two CSP/SP organizations which provide both direct supports and conflict free case management, and one private Intermittent Care Facility for Intellectual and Developmental Disabilities (ICF/IID). Data has been aggregated for calendar year 2016. The Division of Development Disabilities' (DDD's) intent is to issue a comprehensive trend analysis on an annual basis while providing specific reports to each provider on a quarterly basis. The purpose of the report is to communicate information about trends, remain vigilant for emerging issues, and use data to plan, prioritize, and implement preventative and proactive initiatives. The DDD hopes these reports will be helpful to administrators in support of their organization's continuous quality assurance and improvement systems including managing their internal incident reporting system and comparing their data with statewide aggregate information.

Included in this document is the following data analysis of all CIRs for all providers for 2016:

◊ Total number of persons supported by CHOICES waiver, CTS funding, and private ICF/IID funding;

◊ Total number of incident reports submitted;

◊ A breakdown of reports by category; and

◊ Information regarding the total statewide number of incidents by category.

Highlights

◊ **2,827 participants are on CHOICES HCBS Waiver, CTS, or Private ICF in 2015.**

◊ **The 2016 CIR Annual Report marks the eleventh annual of CIR trend reporting, issued by DDD.**

◊ **15,810 CIRs have been reviewed through annual CIR reporting.**

◊ **Collaboration with the Medicaid Fraud Control Unit, Child Protection Services (CPS), and Long Term Services and Supports (LTSS), formerly Adult Services and Aging is ongoing.**

MISSION STATEMENT

To ensure that people with developmental disabilities have equal opportunities and receive the services and supports they need to live and work in South Dakota communities.

PRINCIPLES

1. We will support people to participate in the life of their community.
2. We will honor the importance of relationships with family and friends.
3. We will ensure that quality services are available and accessible.
4. We will work with providers to enhance services while respecting the dignity of risk and the importance of health and safety.
5. We will respect and value cultural diversity.
6. We will be good stewards of public funds.

2016 Critical Incident Reporting: Trend Analysis

OVERVIEW

The Division of Developmental Disabilities (DDD) created an online reporting system for Critical Incident Reports (CIR) which was implemented on January 1, 2005. The system allows Community Support Providers (CSPs) to submit required reports electronically and allows the DDD to analyze data. The purpose of developing an online reporting system was to streamline the reporting process for CSPs. Implementation of this system coincides with the first day of the calendar year; therefore, CIR Annual Reports are issued according to the calendar year rather than the fiscal year.

The population covered by the CIR system includes all people receiving services funded through the DDD's CHOICES Waiver[1], Community Training Services (CTS) and private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (LifeScape). Policy Memorandum 11-02 stated that although the DDD does not have authority to require providers to report allegations of abuse, neglect, exploitation of non-division funded persons, it is best practice and ensures due diligence to report these allegations. Providers have obtained releases of information from these participants and/or their guardians who do not receive Home and Community Based Services (HCBS) or CTS. Providers began submitting these incidents in September 2010.

---

[1] CHOICES is the name of the Division of Developmental Disabilities' Home and Community Based Services Comprehensive Waiver. It is an acronym for Community, Hope, Opportunity, Independence, Careers, Empowerment, Success. In this report, the term HCBS will be used to reference the CHOICES waiver program.

REGULATORY AUTHORITY

The authority behind the submission of incident reports is as follows:

46:11:03:02. Critical incident reports -- Submission to division. The provider shall give verbal notice of any critical incident involving a participant to the division no later than the end of the division's next business day or the provider's next administrative business day, whichever occurs first, from the time the provider becomes aware of the incident. The provider shall submit a written critical incident report utilizing the division's on-line reporting system within seven calendar days after the initial notice is made. A report must be submitted for the following:

   (1) Deaths;

   (2) Life-threatening illnesses or injuries;

   (3) Alleged instances of abuse, neglect, or exploitation against or by any participant;

   (4) Changes in health or behavior that may jeopardize continued services;

   (5) Serious medication errors;

   (6) Illnesses or injuries that resulted from unsafe or unsanitary conditions;

   (7) Any illegal activity involving a participant;

   (8) Any use of physical, mechanical, or chemical intervention, not part of an approved plan;

   (9) Any bruise or injury resulting from the use of a physical, mechanical, or chemical intervention;

  (10) Any diagnosed case of a reportable communicable disease involving a participant;

  (11) Alleged instances of corporal punishment, seclusion, denial of food, or other practices prohibited in SDCL 27B-8-42; or

  (12) Any other critical incident as required by the division.

The report must contain a description of the incident, specifying what happened, when it happened, and where it happened. The report shall also include any action taken by the provider necessary to ensure the participant's safety and the safety of others and any preventative measures taken by the provider to reduce the likelihood of similar incidents occurring in the future. The division may re-quest further information or follow-up related to the critical incident.

The provider shall notify the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, that a critical incident report has been submitted and the reason why unless the parent or guardian is accused of the incident.

REGULATORY AUTHORITY

46:11:03:01.   Provider policy on abuse, neglect, and exploitation. A provider shall have a policy approved by the division which prohibits abuse, neglect, and exploitation of a participant. The policy shall contain the following:

(1) Definitions of abuse, neglect, and exploitation pursuant to SDCL 22-46-1;

(2) A procedure to report to the division pursuant to § 46:11:03:02;

(3) A procedure to report to the Department of Social Services pursuant to SDCL 26-8A-3 to 26-8A-8, inclusive, or SDCL 22-46-7 to 22-46-11, inclusive;

(4) A procedure for an internal investigation that includes:

   (a) Initiation of the investigation within 48 hours or the next business day, whichever is later;

   (b) Issuance of preliminary investigation findings to the division within seven calendar days of initiation of the investigation;

   (c) Issuance of the final investigation findings to the division within 30 calendar days of initiation of the investigation;

(5) A procedure for remediation to ensure health and safety of participants;

(6) A procedure for disciplinary action to be taken if staff have engaged in abusive, neglectful, or exploitative activities;

(7) A procedure to inform the guardian, the parent if the participant is under 18 years of age, and the participant's advocate, if any, of the alleged incident or allegation and any information not otherwise prohibited by court order about any action taken within 24 hours after the incident or allegation, unless the person is accused of the alleged incident;

(8) Upon substantiating the allegation, a procedure to communicate investigation results to the participant, to the participant's parent if the participant is under 18 years of age, or to the participant's guardian or advocate, if any. The provider shall document the actions to be implemented to reduce the likelihood of and prevent repeated incidents of abuse, neglect, or exploitation;

(9) A procedure for training the participant, the guardian or the participant's advocate, if any, and any family members as identified by the participant, upon admission and annually thereafter, on how to report to the provider and division any allegation of abuse, neglect, or exploitation. The provider shall document the date, time, and content of this training;

(10) A requirement that the training include what actions by the participant, the guardian or the participant's advocate, if any, may take when not satisfied with the action taken or the outcome;

(11) A requirement that the training shall be provided in an accessible format; and

(12) A requirement that retaliation against a participant, the participant's parent if the participant is under 18 years of age, the participant's guardian or advocate, if any, is forbidden. Retaliation is also forbidden against a whistle blower pursuant to SDCL 27B-8-43.

2016 Quarterly Incident Totals By Provider

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
ABS	6	8	14	21
ADVANCE	19	19	8	7
Aspire	7	4	24	12
BHS/BMK	*	*	4	5
BHSSC	11	11	15	15
BHWTC	31	34	49	37
LS-CCHS	20	24	21	36
CCI	3	5	10	10
DM	16	17	7	9
DA	12	11	14	25
ECCO/Valiant	7	13	14	9
HACFI	23	26	23	27

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
LQ	8	16	20	27
LIVE	12	12	4	1
NH	20	30	34	26
NHCM	*	*	0	0
NHTC	15	19	29	27
OAHE	21	35	51	35
RHD	*	*	0	5
SESDAC	14	24	18	7
LS-SDA	56	76	50	72
LS-SDA CM	*	*	0	0
SEBHC	18	24	31	21
VOA	24	25	18	50

This chart captures data on all 2016 incident reports, by quarter, for each provider organization.

*Conflict-Free Case Management providers entered the system in the third quarter of 2016.

CIR REVIEW PROCESS

The process for managing the CIR system is a joint collaboration between the DDD and each of South Dakota's CSPs. Each CSP is commended for fulfilling the responsibilities related to CIR notification to the DDD, submission of CIRs, and responsiveness to the DDD's requests for follow-up.

Each CSP is each assigned a Program Specialist who is responsible for reviewing all CIRs submitted by that CSP. DDD nurses review all CIRs that involve health, medication, injury, unplanned hospitalizations or medication issues. The DDD also has a process which coordinates a peer review for all CIRs designed as a Quality Assurance (QA) mechanism. The CIR/QA team's duties are designed to ensure all necessary follow-up is completed, timelines are met, and any additional third party reporting (e.g., to the Attorney General's Medicaid Fraud Control Unit (MFCU), Law Enforcement, CPS, or LTSS) has occurred. The peer review process has increased the DDD's ability to address CIR inconsistencies both internally and systemically.

The CIR/QA team also collects quarterly data and reviews trends by provider and CIR category.

A root cause analysis process is used to determine areas of concern which might benefit from changes in policy and practice. A root cause analysis is a process for identifying the causal factors which underlie variation in performance, including the occurrence of a sentinel event. As trends are identified, DDD Program Specialists are responsible for addressing issues with their assigned provider(s).

SYSTEMS IMPROVEMENTS IN 2016

1) The CIR/QA team conducted annual training to provide education to provider staff. Training included review of CIR Guidelines, basic reporting requirements clarification regarding the online incident reporting system, and correct categorization of incidents.

2) Collaboration with the MCFU, CPS, and LTSS occurred on an on-going basis this year.

3) Program Specialists conducted technical assistance with fifteen providers as training needs were identified by the providers or through the quarterly monitoring incident review and analysis.

4) Training has occurred on an ongoing basis for Program Specialists and provider staff to ensure reporting accuracy.

5) In 2016 Conflict Free Case Management began, and participants chose or were assigned SPs to provide case management. Therap was chosen as the comprehensive system, and all providers shifted to reporting in Therap January 1, 2017. A pilot involving Volunteers of America was conducted during the fourth quarter of 2016.

6) The 2016 annual report includes a new section focused on highly restrictive measures such as physical restraint, time out, mechanical restraint, and chemical restraint.
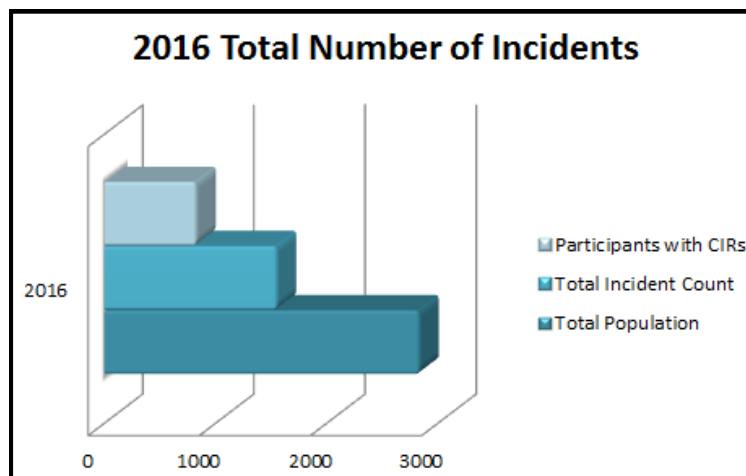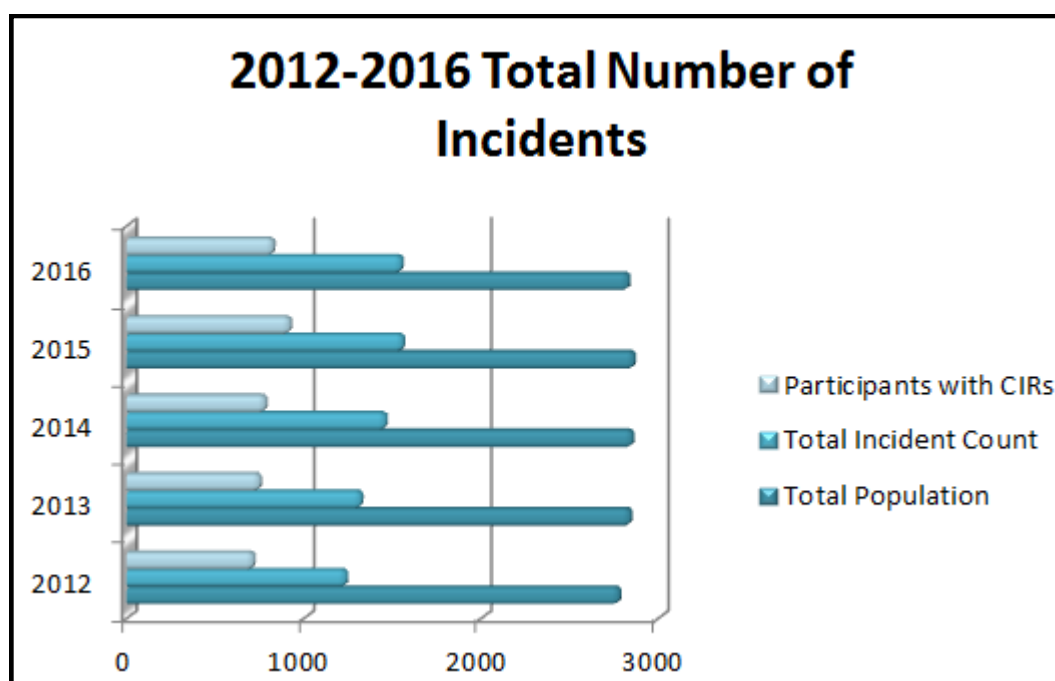
Total Numbers of Incidents

In 2016, the number of persons supported through HCBS CHOICES, CTS and Private ICF/IID funding decreased by thirty-one, and the number of participants for whom critical incidents were reported also decreased by ninety-four participants from 2015. In 2017 the information on participants supported will be taken from a different source which is not tied to specific organizations as participants who transfer from provider to provider in a given quarter could be counted twice in the current participant count. This year's actual overall growth in population is close to one hundred participants.

The total incident count for 2016 was 1,546 which is a decrease of nine incidents from 2015.

These incidents were submitted for 822 participants, or 32.05% of all participants in South Dakota receiving supports and services . This number was 27.31% in 2015 with 916 participants.
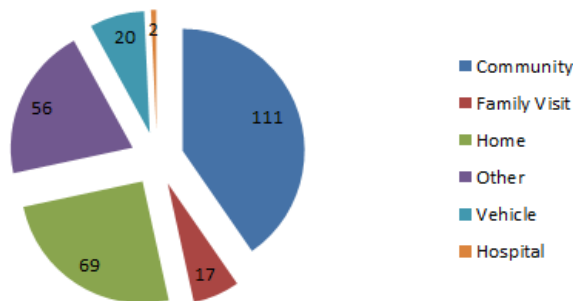

The total population supported has increased in the past seven years until 2016. (See note above related to population data in future years.) There was a decrease from 1,555 to 1,546 total incident reports in 2016. A change to the overall system related to conflict-free case management and a revised ISP, individual support plan, process may be credited with this decrease, although further data analysis in upcoming years will aid in further analysis of this potential trend.

	Total Population	Total Incident Count	Participants with CIRs	% of Participants with CIRs
2007	2481	1852	855	34.46%
2008	2475	1714	809	32.69%
2009	2528	1594	782	30.93%
2010	2575	1004	572	22.21%
2011	2707	1213	698	25.79%
2012	2776	1234	711	25.61%
2013	2837	1319	747	26.33%
2014	2849	1457	778	27.31%
2015	2858	1555	916	32.05%
2016	2827	1546	822	29.08%

The table above reflects the fluctuation in population, incident count, and number of participants for whom CIRs were reported over the last ten years. The difference in the number of total incidents versus the number of participants is due to the fact that several CIRs may be submitted for the same participant throughout the year.
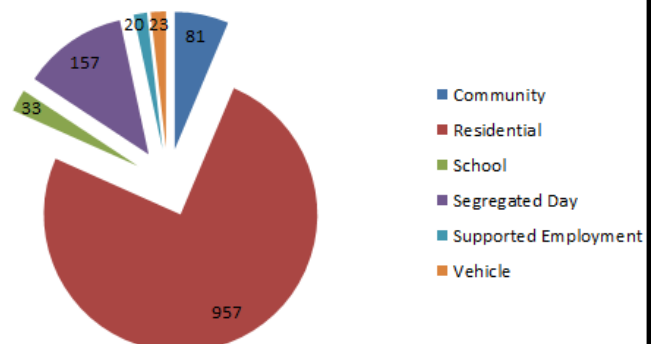
2016 Location when not in Provider Support

Community — 111
Family Visit — 17
Home — 69
Other — 56
Vehicle — 20
Hospital — 2

Incidents which occur while people are outside of provider support happen most frequently in the community with 111 reports. This data reflects that participants are accessing the community by themselves or with natural support networks and includes a variety of locations. Sixty-nine incidents occurred while people were at home. This includes participants who reside in supported living environments and receive minimal residential supports as well as participants who live homes with family members. Fifty-six incidents occurred at Other locations, which include, but are not lim-ited to, clinics, hospitals, and local events/businesses.

Incidents primarily occur at residential settings and segregated day settings as participants are likely spending most of their time in these envi-ronments. Residential settings had 957 reported incidents and segregated day settings had 157 re-ported incidents. Significantly fewer incidents oc-cur while participants are at Other locations in the community, supported employment, school, and in vehicles. The data may also indicate that inci-dents are less likely, due to the training which has occurred with providers and staff, as well as peer reviews and follow up by the program specialist.

2016 Location when in Provider support

Community — 81
Residential — 957
School — 33
Segregated Day — 157
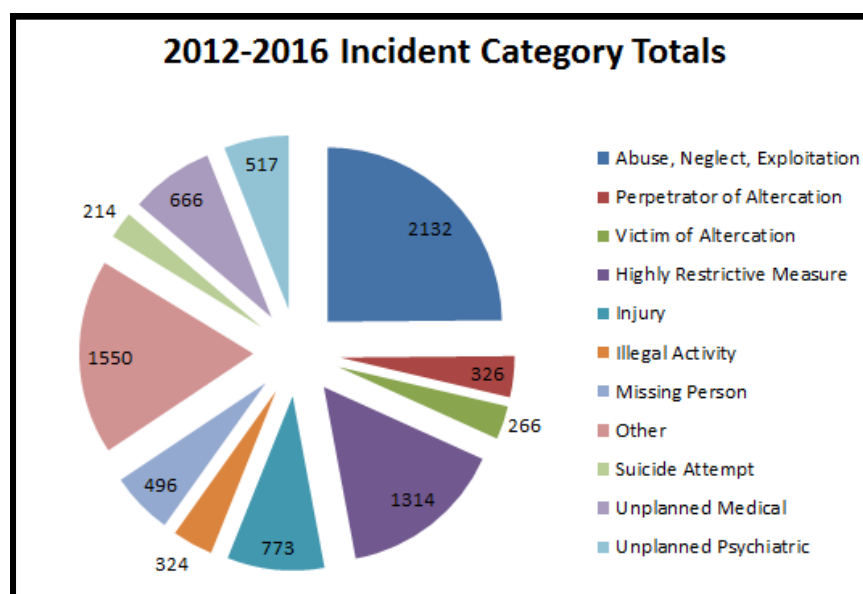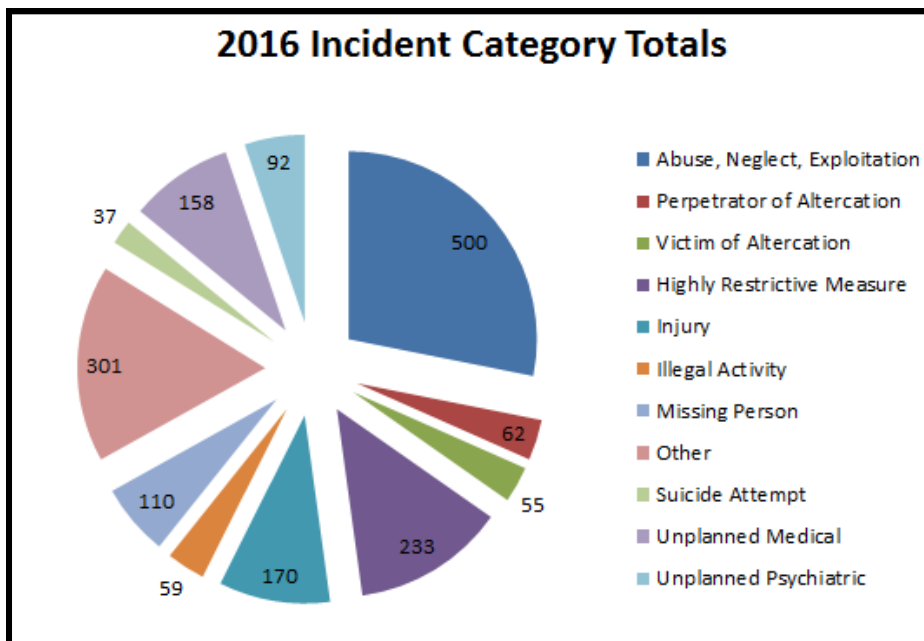Supported Employment — 20
Vehicle — 23

In 2016, the CIR category most frequently reported to DDD was Abuse, Neglect, Exploitation (ANE) with 500 reports. The second highest category reported was Other with 301 incidents. The third highest reported category is Highly Restrictive Measures. This is consistent with the 2015 incident counts. The other incident categories includes such types as Death, Jeopardizing Services, Increase in Behavioral Issues, Communicable Disease, and Medical Diagnosis.

The category with the lowest number of incidents reported to the DDD was Suicide Attempt with thirty-seven reports. Second most reported was Illegal Activity with fifty-nine reports. Missing Person with sixty-two reports was third most prevalent.

2016 Incident Category Totals

Abuse, Neglect, Exploitation: 500
Perpetrator of Altercation: 62
Victim of Altercation: 55
Highly Restrictive Measure: 233
Injury: 170
Illegal Activity: 59
Missing Person: 110
Other: 301
Suicide Attempt: 37
Unplanned Medical: 158
Unplanned Psychiatric: 92

Incident reporting trends for 2012 through 2016 show ANE and Other being the most frequently reported incidents over the past ten years. ANE reporting has ranged from 206 reports in 2012 to 513 reports in 2015 with an average of 426 incidents per year between 2012-2016.

The Other category has a total of 1,550 reports in the five year span of time. Numbers have been fairly steady with 284 being the lowest in 2014 and 354 being the highest in 2015. This was likely due to the wide variety of areas encompassed by the Other category.

2012-2016 Incident Category Totals

Abuse, Neglect, Exploitation: 2132
Perpetrator of Altercation: 326
Victim of Altercation: 266
Highly Restrictive Measure: 1314
Injury: 773
Illegal Activity: 324
Missing Person: 496
Other: 1550
Suicide Attempt: 214
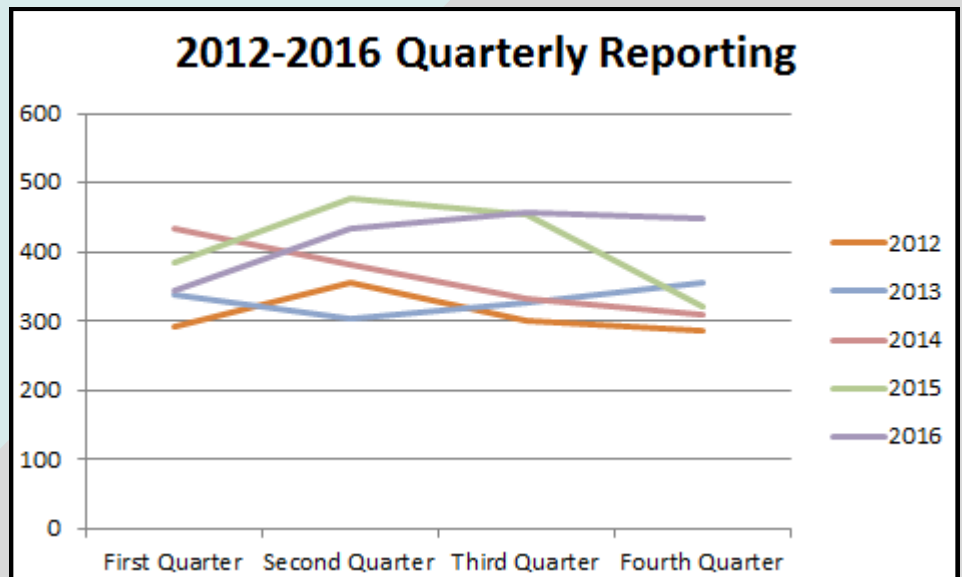Unplanned Medical: 666
Unplanned Psychiatric: 517

QUARTERLY REPORTING

Data for 2016 reflects fairly consistent levels of incident reporting from quarter to quarter, though the first quarter of the year appeared lower than typical trends.

2016 Quarterly Reporting

The table to the right contains total incident counts per each quarter for the past five years.

2012-2016 Quarterly Reporting

Mean, Median, Mode, and Range

Mean: Average
Median: Middle
Mode: Most
Range: biggest - smallest

Incident counts range from 291 in 2012 to 458 in 2016.
The median value captured is 350 incidents per quarter per year.
The mean of the data is 367 incidents per quarter per year.

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
2012	291	356	301	286
2013	337	303	327	356
2014	434	381	332	310
2015	385	477	453	321
2016	343	433	458	449

ABUSE, NEGLECT, AND EXPLOITATION

Abuse, Neglect, and Exploitation (ANE) is typically the highest volume of CIRs reported most frequently across the system. Suspected abuse had been the most frequently reported of the three sub-categories from 2007 until 2015 when suspected neglect surpassed suspected abuse as the highest reported type of allegation for the first time by twenty-eight reports and thirty-six reports in 2016. Exploitation has remained fairly steady in the past five years with a variance of eight reports.

2012-2016 Abuse, Neglect, and Exploitation Reporting

In 2016, incidents of ANE decreased by thirty reports from 2015. Allegations against Community Member, Person Supported, Guardian and Unknown decreased. Allegations against Family Member and Staff increased slightly. Incidents in which staff were accused of ANE totaled 350, which is an increase of eleven reports from 2015.
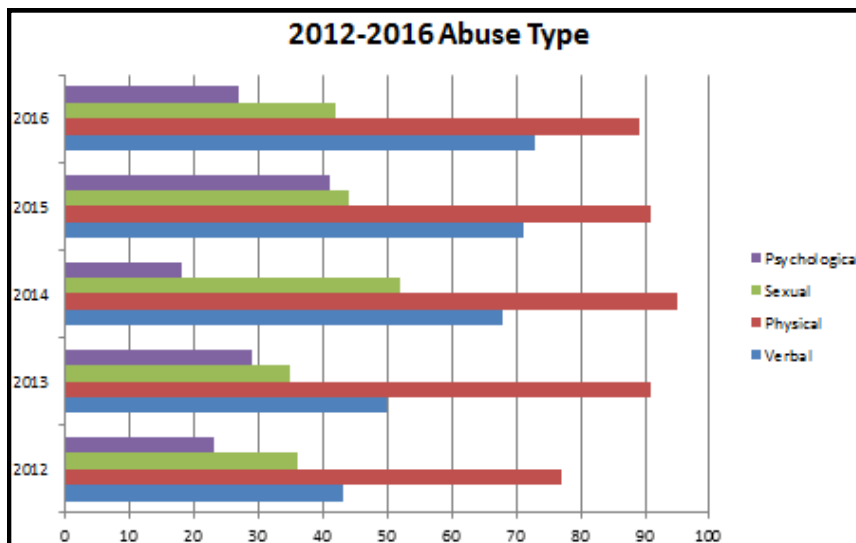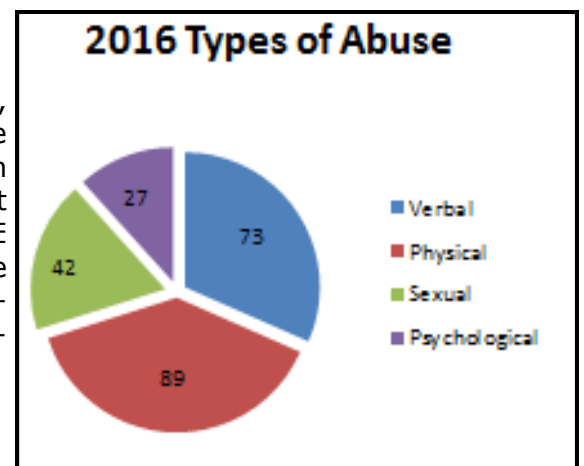

2016 Types of ANE

2016 Suspects of ANE

ANE Training

Participants, guardians, advocates, and family members as identified by the person receive training on ANE and how to report allegations of ANE. This training is required to be provided in an accessible format upon admission, annually thereafter, and documented in the person's Individual Support Plan.

Data from 2012 to 2016 on substantiation rates appears in the chart to the right. The chart demonstrates the increase in ANE reporting and also the substantiation rate. After analysis of the categorized incidents as neither substantiated nor unsubstantiated, it was determined that investigations conducted by the provider were inconclusive. Training was provided in December of 2016 to CSPs regarding these reports. With the information on Therap as described in this report, GER Resolution forms are required for all ANE reports beginning in 2017. The GER Resolution forms should be helpful in decreasing the unspecified category for ANE substantiation as the document requires detail and has a section related to substantiation.

2012-2016 ANE Substantiated

Legend: Substantiated, Unsubstantiated, Unspecified

Abuse CIRs are further delineated into Verbal, Physical, Sexual, or Psychological Abuse. In 2016, Physical Abuse was the most frequently reported type of abuse with eighty-nine of the 231 reports. On the overall incident page of this report, data on Abuse reflects 500 total ANE reports. The explanation for the differing amounts is there are often multiple areas captured in a single CIR. For example, both verbal and physical abuse or verbal and sexual abuse often occur in the same incident.

2016 Types of Abuse

Verbal 73
Physical 89
Sexual 42
Psychological 27

2012-2016 Abuse Type

Legend: Psychological, Sexual, Physical, Verbal

As the graph at left indicates, the number of allegations of Physical Abuse and Verbal Abuse are consistently higher than other types of Abuse. The number of reported Sexual and Psychological allegations are the lowest over the past five years of data collection.

SMART

In 2011, DDD began utilizing the Systemic Monitoring and Reporting Technology (SMART) to monitor CSP compliance. The Continuous Quality Improvement model is followed in identifying areas that may require response and remediation.
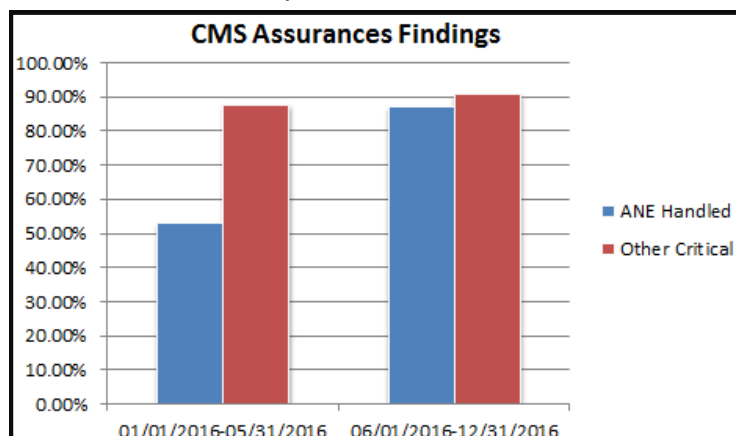

Each month a representative random sample of participant names are selected from across the HCBS Waiver. Files are selected from each of the nineteen CSPs annually. Assigned Program Specialists conduct monthly file reviews of information submitted for review by CSPs for those participants selected. If additional information is needed it is requested from the provider.

SMART elements and causal factors relate to Waiver Assurances, South Dakota Codified Law, and Administrative Rules of South Dakota. Citations are made when the provider does not meet requirements within SMART. Providers then respond and remediate findings for each file. Program Specialists review quarterly data from monthly SMART file reviews with providers. Trends are identified and training is provided as warranted.
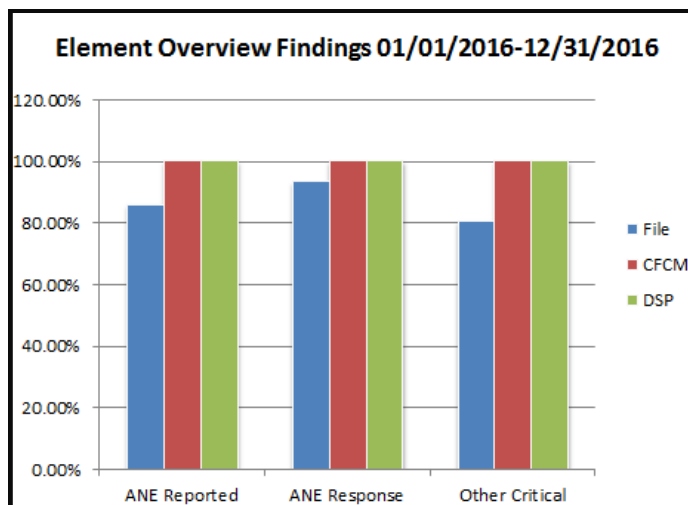
On an biennial basis, Policy Implementation Reviews take place onsite at each CSP. During these reviews each CIR is reviewed for timeliness of both written and verbal reports to DDD and the report to appropriate party if CIR is an allegation of abuse, neglect, or exploitation.

The SMART CMS Waiver Assurances report is designed to run based on fiscal year so there will are two sets of that data for 2016. The elements are Other Critical Events and ANE Handled Appropriately.

The SMART system captures data on file reviews within the representative random sample of files selected for monthly DDD reviews. As the SMART system aligned with the CFCM initiative, the graph, left, demonstrates File as capturing pre-CFCM data, CFCM relates to the file reviews for case management, and DSP is related to the CSP file reviews.

ANE Reporting captures the reporting of ANE allegations and incidents to appropriate parties including mandatory reporting.

ANE Response includes information related to findings of investigations and ensuring preventative actions are developed adequately.

Other Critical Events assesses the CIRs which are not ANE-related for identification, timeliness, and responsiveness.

DDD ACTIONS TAKEN:

In 2016, reports were ran quarterly, indicating all providers at or below the CMS threshold of an 86% rate of compliance, the CMS compliance rate, for ANE Reporting, ANE Response, and Other Critical Events and discussion with providers and technical assistance were offered. Program Specialists continue to monitor SMART data on a quarterly basis with the providers and have discussions within the division related to trends.

Also in 2016 Division staff formed small SMART groups so provider data can be discussed on a more focused basis.

MEDICAID FRAUD CONTROL UNIT:

The Division partners closely with the Medicaid Fraud Control Unit (MFCU) with the same goal which is to ensure quality supports are provided. MFCU reviews three types of cases which include billing issues, ANE, and failure of care (neglect).

DDD program specialists report the following types of CIRs to MFCU for those people whose supports are paid through Medicaid:

• Allegations of ANE against staff;

• All allegations of ANE between persons supported by providers as well as those considered to be altercations between people supported;

• Exploitation allegations where social media, texting, or photographs of participants are involved;

• Unexplained injuries;

• Injuries sustained as a result of physical restraint; and

• Mortality reports where death was not anticipated. See pages 22-26 for more information related to mortality CIRs.
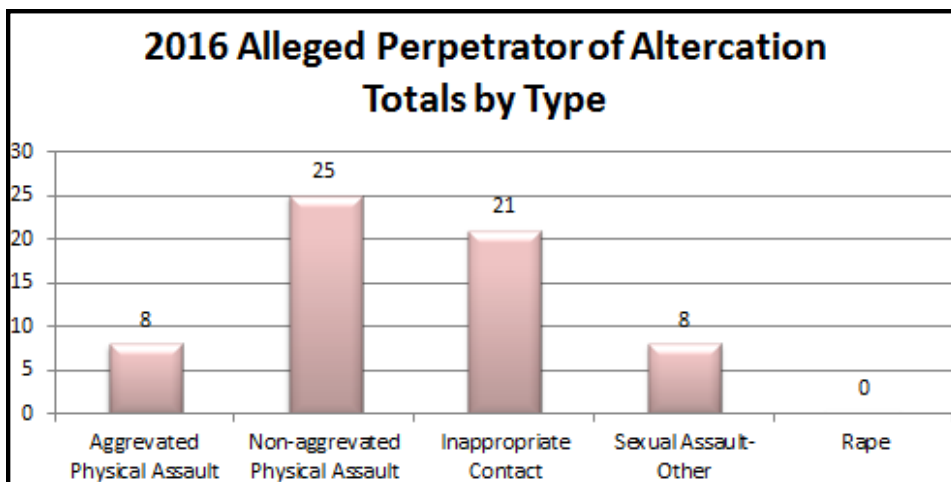
MANDATORY REPORTING

SDCL 22-46-7: Requires that reports of abuse, neglect, or exploitation be made to the State's Attorney's Office, the Department of Social Services, or to law enforcement. Reports must be made within 24 hours. In 2017 the Adult Services and Aging portion of DSS is slated to move to the Department of Human Services and become Long Term Services and Supports. Reports will continue to be made for adults to LTSS and for children the reports will continue to Child Protection Services and DSS.

ALLEGED PERPRETRATORS OF ALTERCATIONS

The information below indicates that there were twenty-five incidents in which a participant was the Alleged Perpetrator of Non-aggravated Physical Assault, twenty-one incidents of Inappropriate Contact allegations, eight Aggravated Physical Assault allegations, eight Sexual Assault-Other allegations, and no incident where participants were accused of Rape. These numbers are consistent with 2015 data.

Assault includes physical actions towards another person. Sexual assault, inappropriate contact, and rape are related to sex-driven altercations. These can include unwanted physical and non-physical sexual contact and exploitation. Examples include when a person is unable to give consent or if the act is against their wishes and/or exposed to pornography or verbal sexual harassment.

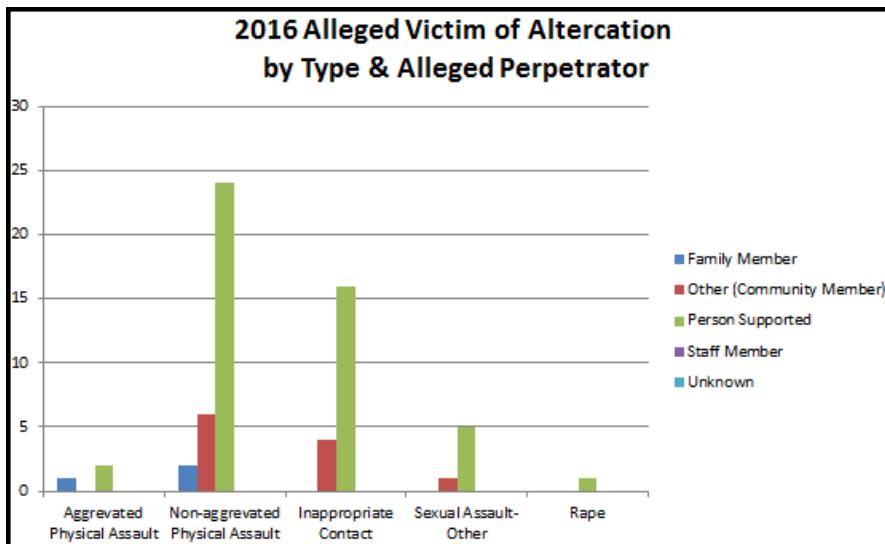2016 Alleged Perpetrator of Altercation Totals by Type

The distinction between aggravated and non-aggravated incidents is weapon usage. If a weapon is utilized during the incident the report would be considered aggravated.

ALLEGED VICTIMS OF ALTERCATIONS

In 2016 there were sixty-one total reports of participants being victims of altercations in the CIR system. A person may be a victim of an altercation versus abuse if they weren't the intended victim, if a crime was committed against the person without the perpetrator being aware of the victim being a vulnerable adult (for example a bar fight), if there was an act of aggression and the participant was relatively unaffected by the incident, or if there was a mutual altercation between two participants resulting in an injury.

Inappropriate contact occurred in 2016 twenty times. Non-aggravated physical assault decreased in 2015 from thirty-two to sixteen reports, but in 2016 rose again to thirty-two reports. Aggravated physical assault has remained at three from 2015 to 2016. There were two victims of rape in 2015 and one in 2016. Sexual Assault-Other decreased from eight to six from 2015 to 2016.

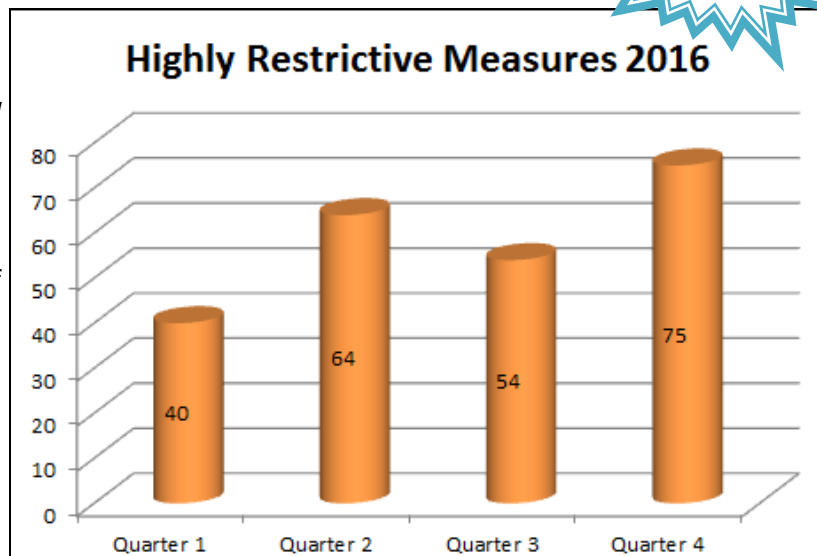2016 Alleged Victim of Altercation by Type & Alleged Perpetrator

Victims of Altercations were largely represented by other persons served with forty-seven total incidents in that category; eleven incidents were committed by community members. The remaining three reports involved family. Perpetrators of Altercations in 2016 did not include staff because these incidents would typically be captured as abuse in the ANE category.

HIGHLY RESTRICIVE MEASURES

Highly Restrictive Measures include any use of physical, mechanical, or chemical intervention. Examples include *physical restraints, mechanical restraints, chemical restraints,* use of *time-out* (time-out may only be used as part of an approved behavior support plan) and other techniques with similar degrees of restriction or intrusion, e.g. preventing egress from vehicles and/or rooms, as described in ARSD. All highly restrictive procedures must receive due process through the agency's Human Rights Committee and Behavior Intervention Committee.

Highly Restrictive Measures 2016

Quarter	Value
Quarter 1	40
Quarter 2	64
Quarter 3	54
Quarter 4	75

Any bruise or injury resulting from the use of a physical, mechanical, or chemical intervention is reportable as a CIR in the injury section. All highly restrictive procedures utilized that are part of or not part of an approved behavior intervention plan that result in bruising or injury to the person. Highly restrictive procedures include *physical restraints, mechanical restraints, chemical restraints,* use of *time-out*.

A time-out refers to a highly restrictive procedure in which the participant is denied egress from an enclosed area when exhibiting a problem behavior. A time-out shall follow the criteria in § 46:11:05:06.01 and shall meet the following requirements:

> (1) Provider staff shall provide continuous observation of the participant;

> (2) A time-out may not occur in an enclosed area that may be locked with a key;

> (3) Provider staff shall have immediate access to the participant;

> (4) The use of a designated time-out room is prohibited; and

> (5) A time-out may only be used as part of a behavior support plan approved by both the human rights and behavior support committees.

Time-out may not be used in a punitive fashion. Each use of a time-out may not exceed 15 minutes. If after 15 minutes, the participant continues to exhibit a problem behavior that poses a threat to the participant or others, the use of a time-out may continue for another 15 minutes. The maximum amount of time a participant may be in time-out shall not exceed one continuous hour. The provider shall document any use of the time-out. All highly restrictive procedures must receive due process through the agency's Human Rights Committee and Behavior Intervention Committee.
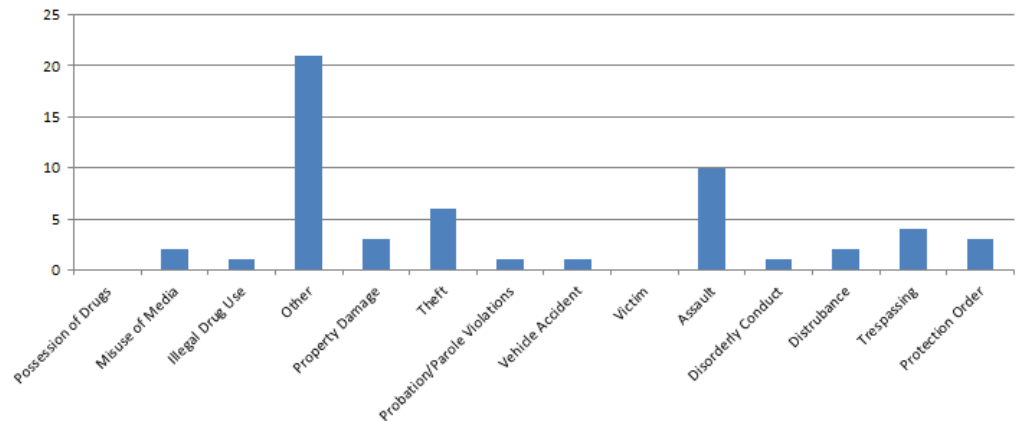
New for 2016, Highly Restrictive Techniques are identified in this report in a specific section. With the introduction of Therap in 2017 system-wide, enhanced trend analysis for this area will be a system improvement for 2017's annual report..
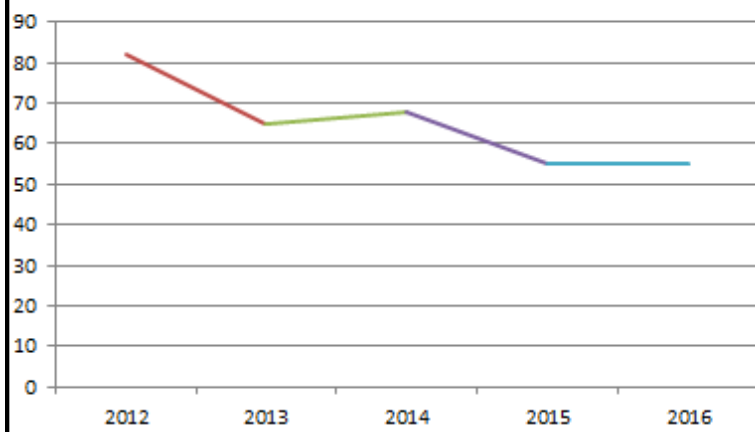
ILLEGAL ACTIVITY

There were fifty-five total illegal activity CIRs in both 2015 and 2016. Other illegal activity is the highest category within this incident type, with assault being second, and theft being third.

With the Conflict-Free Case Management changes, including a new incident reporting system, types of illegal activity will be able to be categorized with more robust options which should address the variety of illegal actions to capture.

2016 Illegal Activity

2012-2016 Illegal Activity

The chart at left demonstrates the steady decrease of illegal activity from 2012-2016, although the past two years have remained stagnant. Illegal activity data is collected only when participants are charged with crimes, not if suspected of completing a crime or if it is unreported to law enforcement such as suspicion that a person is using marijuana. If not reported to police and charges filed, information is not contained in this area; it may, however, be included in the jeopardizing services or increase in the behavior section under the Other category shown on the next page.

There are 2,827 people receiving services in South Dakota. The chart below reflects the *Total Number of People Served who may be involved in multiple Illegal Activities:

With the 2016 report, a comparison of state-wide crimes committed by all people in South Dakota with the CSP population has been completed. Statewide information was taken from the 2016 Crime in South Dakota report by the Office of the Attorney General, Division of Criminal Investigation, Criminal Statistical Analysis Center. This feature was a new addition to the CIR Annual Trend Analysis beginning in 2015.
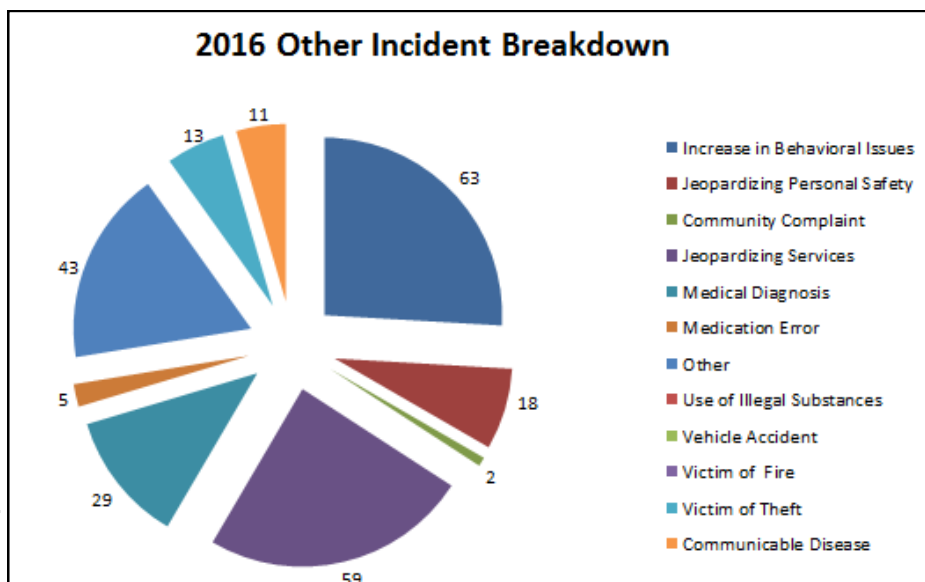
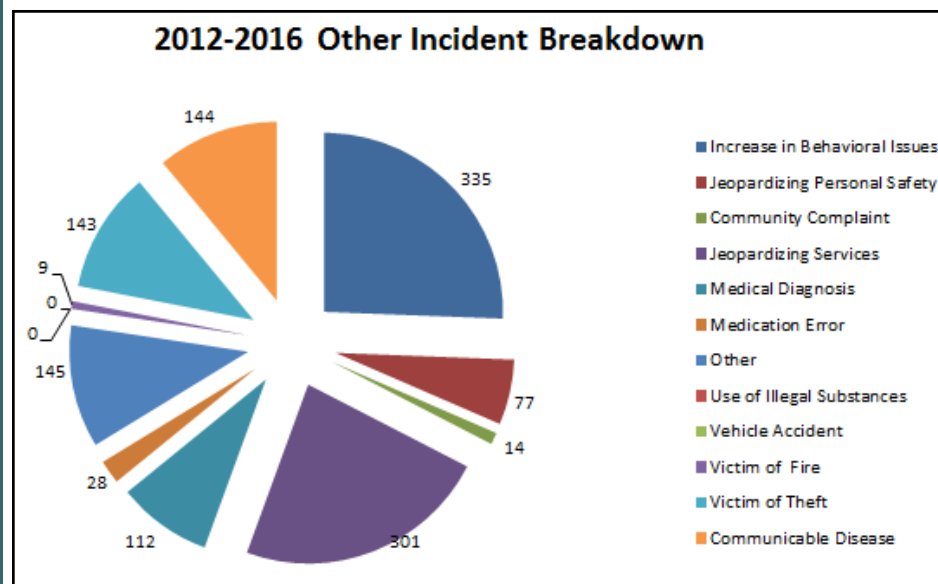|	Total # of People Involved	Illegal Drug Use/Posession	Misuse of Media	Property Damage	Disorderly Conduct	Theft	Assault	Disturbance	Trespassing
•CSP	51	1	2	3	1	6	10	0	4
•Statewide	54155	8949	2	501	1666	3349	4791	469	684

The eight types of crimes were aligned with statewide data. Overall, there were 54,155 crimes in the statewide system. These nine areas comprise 20,411 of those. Other was removed this year for both CSP and statewide data as the categories did not compare as a much broader array of crimes were captured in the statewide other than the CSP other. In the CSP system areas were consolidated to align with those eight and some removed which had little data or were not included as crime types in categories A or B in the statewide system.

OTHER INCIDENTS

There were 243 CIRs which fell into the Other incident category during 2016, which was a decrease from 2015, likely due to teaching and training related to consistency in incident reporting types. These included reports ranging from Communicable Disease to Victim of Theft. There is a distinction between Theft and Exploitation. Exploitation is when the participant is targeted generally for their potential vulnerability; whereas with Theft, it may be unknown to the perpetrator who the victim is or the victim was not known to be a person receiving services. Police Involvement with no arrest or charges would be included in the Other category.

2016 Other Incident Breakdown

The graph below shows data from 2012-2016 for each of the incident reporting categories under Other. 2016 data is consistent with the five-year trend analysis data as well.

2012-2016 Other Incident Breakdown

Technical assistance is on-going in relation to better identification of reports so that they do not appear in the this chart's Other category and can be aligned better within appropriate categories. The shift to the new CIR reporting system this year should ensure consistency in the future.
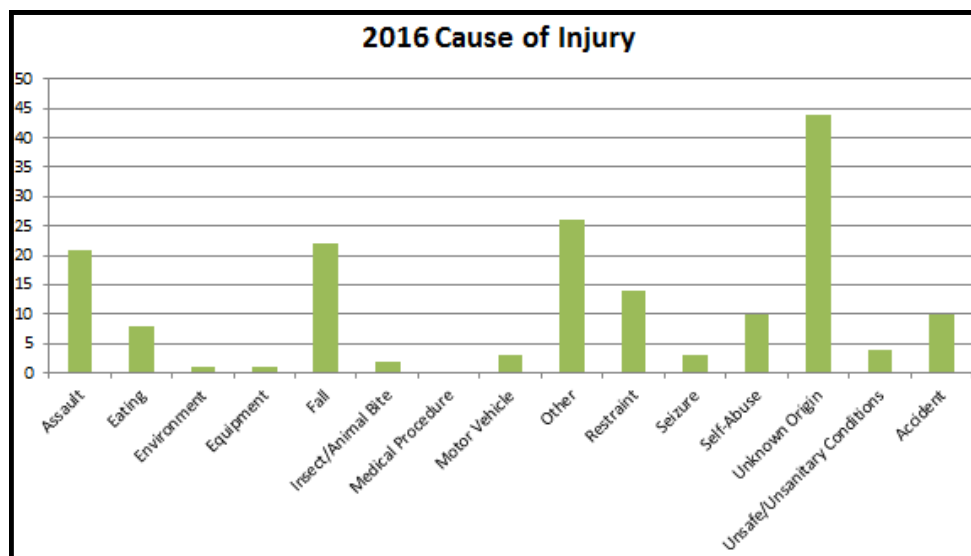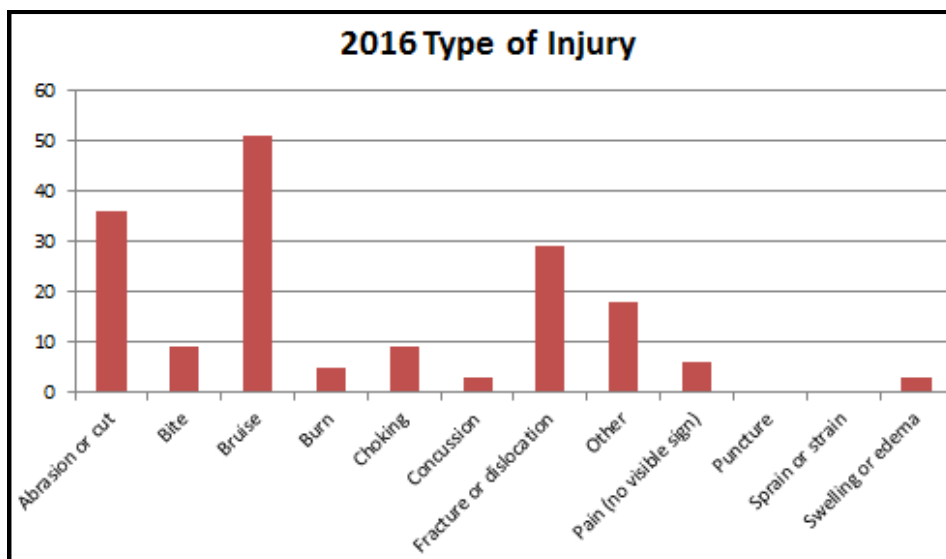
INJURIES:

Reports received by the Division program specialists are referred to Division RN's when they contain medical content such as injuries, hospitalizations, communicable diseases, diagnoses, or deaths.

In 2015, there were 169 injuries reported to DDD compared to 2015 with 149 reports.

Types of injuries were fairly consistent. The Bruise category increased from 2015, but maintained consistency with the 2014 data.

Injuries from Falls, Unknown Origin, and Other rose slightly from 2015. Injury from Assault was reduced this year.

2016 Type of Injury
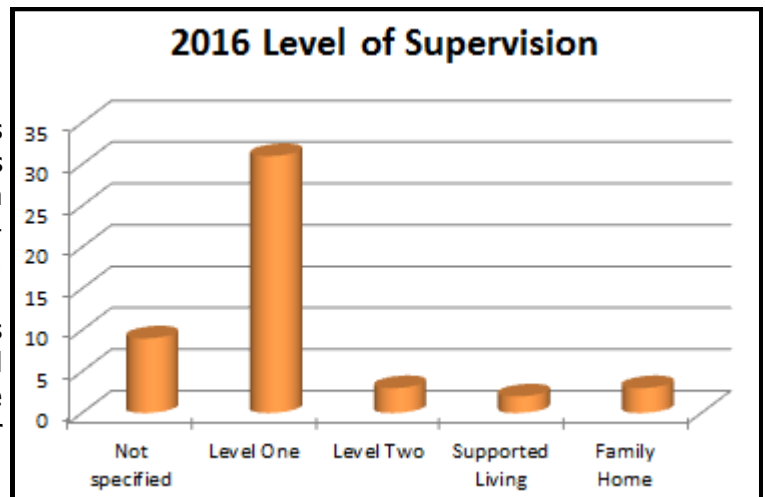
2016 Cause of Injury

MORTALITY ANALYSIS:

By definition, state developmental disability systems support people from an early age until the end of life. Supporting individuals through the end stages of their life is a critical function that CSPs provide to participants. In South Dakota, the relatively low number of deaths each year makes it difficult to detect annual trends. The DDD reviews and investigates all deaths and may perform extended investigations for deaths which are accidental, unexplained, or occur amidst allegations of abuse or neglect. In 2016, forty-eight death reports were submitted by CSPs. The South Dakota Developmental Center reviews a copy of each quarterly analysis of mortality CIRs to help identify any trends or areas for further review.
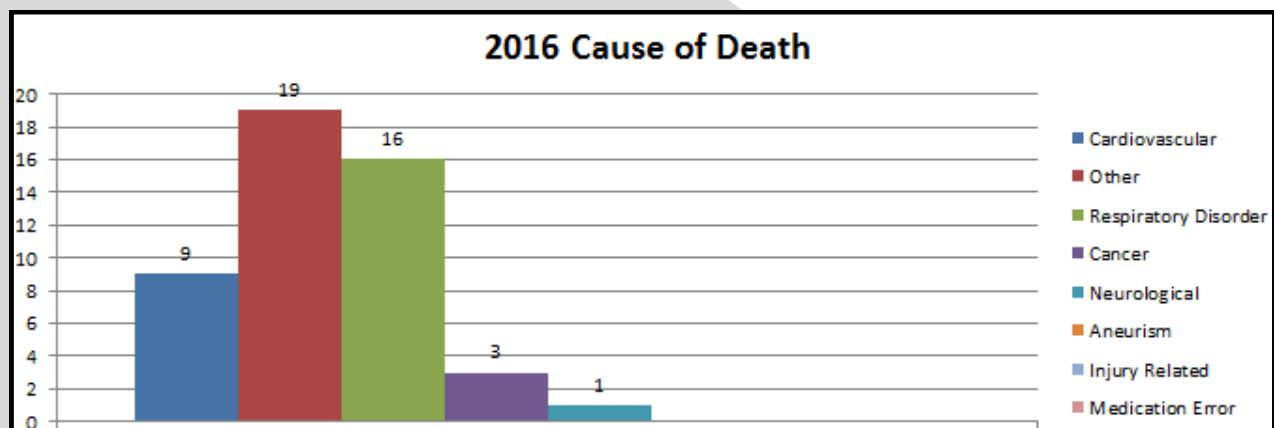
MORTALITY ANALYSIS CONTINUED:

2016 data shows is an increase of six deaths from 2015. Of these, thirty-one participants were receiving residential supports in a Group Home, three in Supervised Apartment, and two in Supported Living settings. Three participants lived in the family home. Instances in which the level of supervision is Not Specified indicates the participant did not receive residential supports from the CSP but received at least one other waiver service, CTS, or private funding.

2016 Level of Supervision

2016 Type of Death

As seen in the graph above, twenty-eight deaths in 2016 were due to Natural Causes-Anticipated and eighteen due to Natural Causes-Not Anticipated, and two Accidental deaths. There were no Homicides reported in 2016.

The leading causes of death in 2016 were Other with nineteen reports followed by Respiratory Disorder with sixteen, and Cardiovascular at nine.

2016 Cause of Death

Legend:
- Cardiovascular
- Other
- Respiratory Disorder
- Cancer
- Neurological
- Aneurism
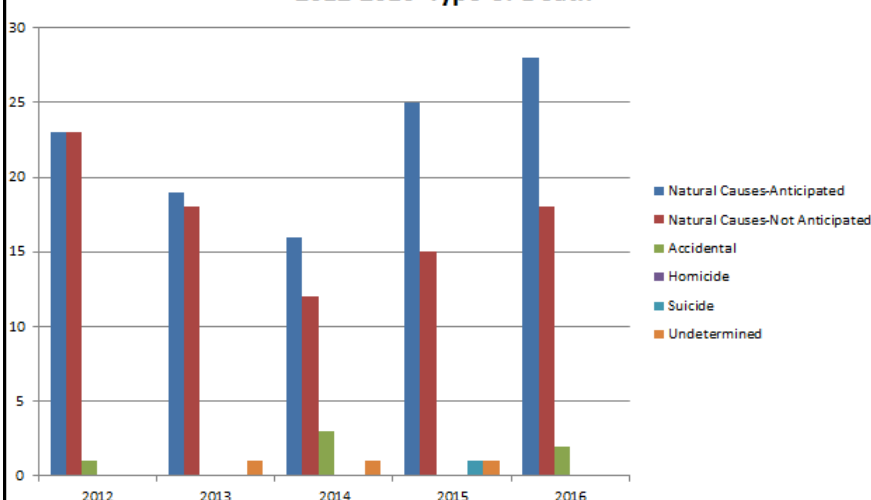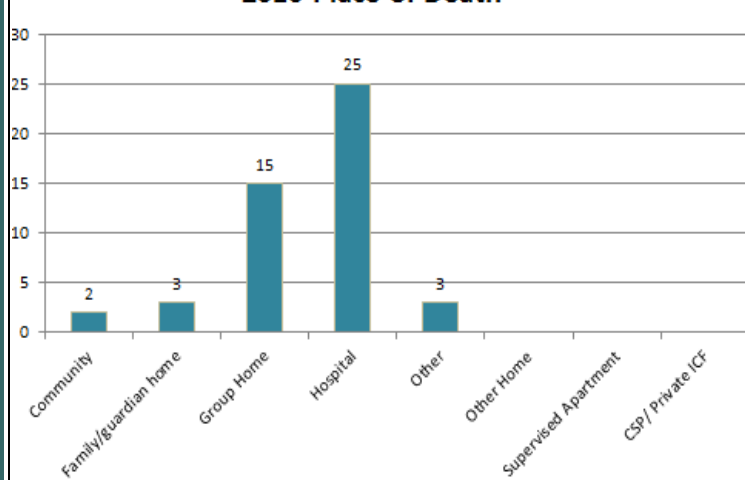- Injury Related
- Medication Error

Types of Death reflects a fairly close range of data likely due to the few deaths in the system each year. Participants commonly discharge to hospice or nursing homes before they pass, so these deaths only account for people who were still receiving services or in the hospital at the time of their mortality.

As the graph below demonstrates, twenty-five of the forty-eight incidents of death occurred in a Hospital, fifteen occurred at a Group Home, three occurred in Other and Family/Guardian homes. Two deaths occurred in the Community.

2012-2016 Type of Death
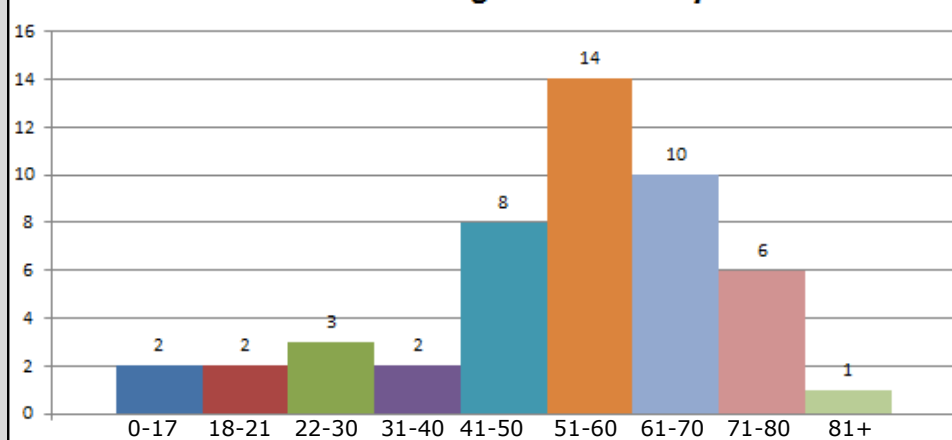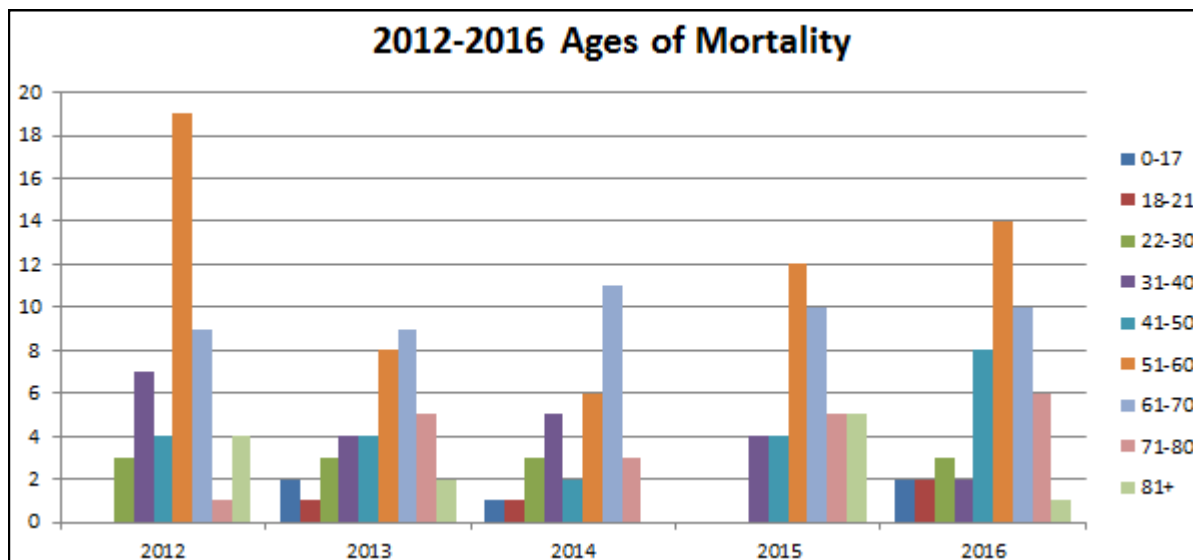

2016 Place of Death

The graph below reflects the number of deaths in each age category. Of the total participant deaths in 2016, fourteen died in the 51-60 year old age range in, ten in 61-70, eight in the 41-50 age range, and six in the 71-80. In 2016 there were child mortalities. There have been seven total child mortalities in the twelve years of CIR data collection. Both participants were supported by one CSP; the participants were ages sixteen and seventeen. One participant passed away outside of direct CSP supports and the other in the hospital after receiving supports from the

provider. Both died of natural causes with no suspicious circumstances. An investigation was conducted by one provider into the circumstances which led to one participant's passing and there were no findings of wrongdoing.
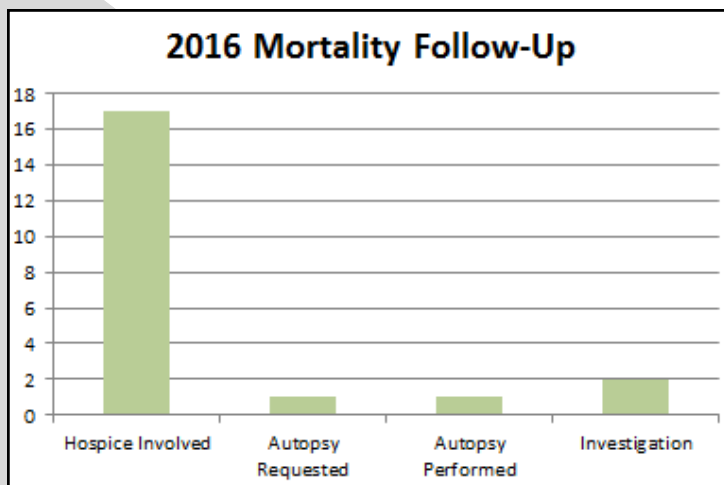
The remaining age ranges experienced one to three mortalities per range.

2016 Ages of Mortality
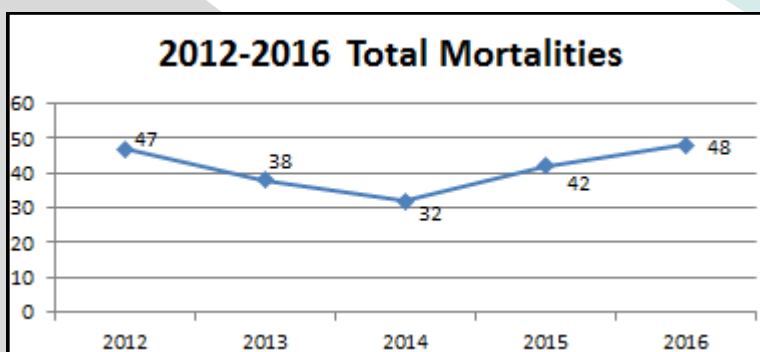
2012-2016 Ages of Mortality

From 2012 through 2016, the ages of death vary, but most deaths have occurred in the age ranges of 51-60 and 61-70. Within the past five years there have been five deaths of participants aged 0-17.

2016 Mortality Follow-Up

Of the forty-eight deaths which occurred in 2016, twenty-eight of these were anticipated and hospice care was provided for seventeen of the people. Investigations were conducted for two separate death reports.
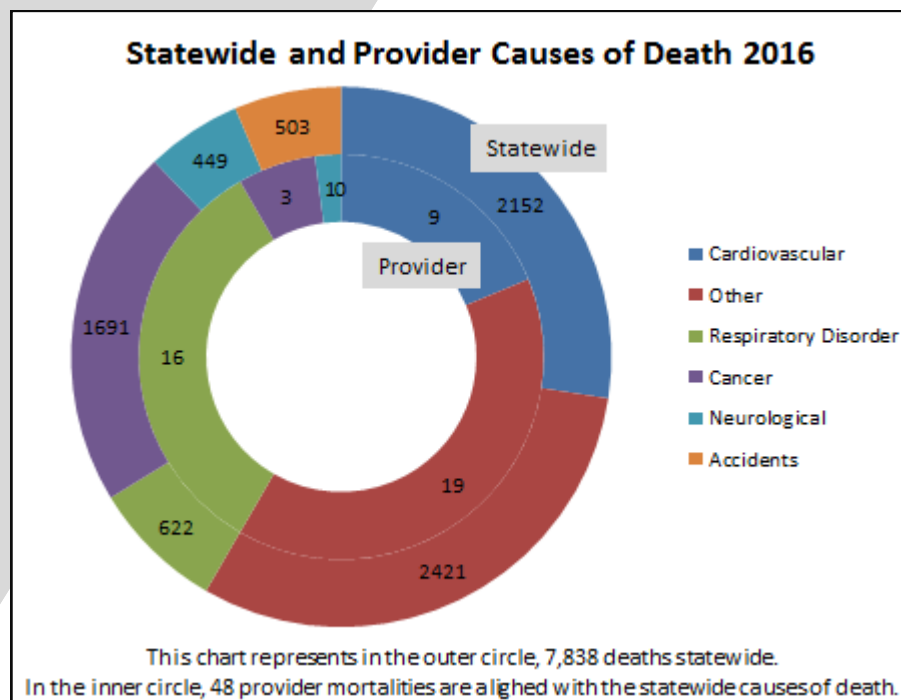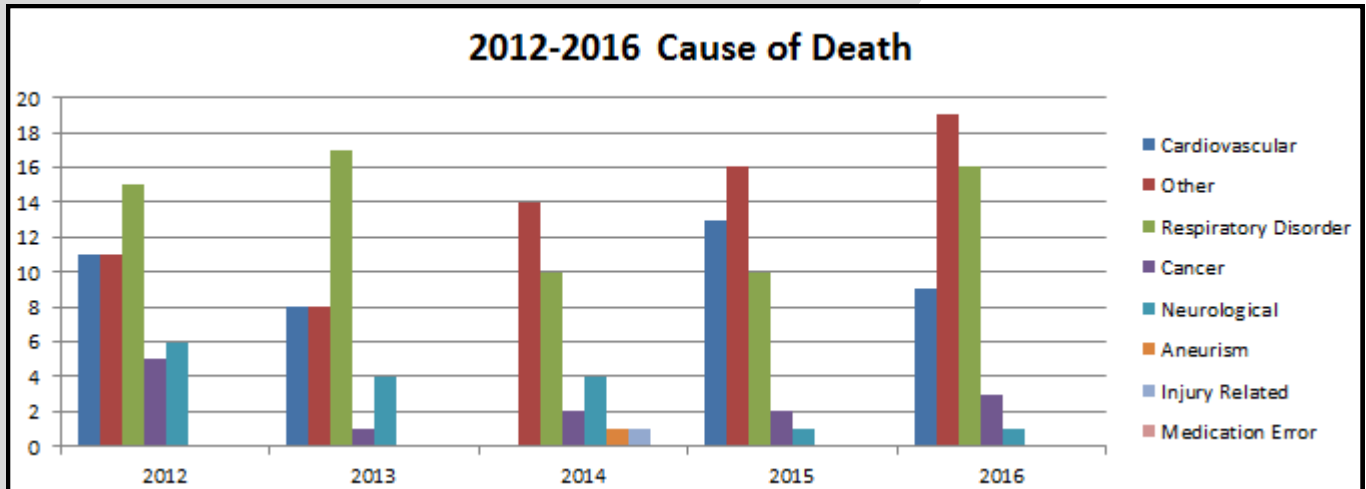
Over the course of the past six years, mortality rates have remained fairly stable. In 2012, the number of deaths increased from the previous years, and had continued to decrease each year until 2014.

In 2015 data rose again. This may be a result of efforts to support participants for longer at their homes. This trend continued through 2016.

2012-2016 Total Mortalities

The leading causes of death from 2012-2016 are Cardiovascular, followed by Other, and Respiratory Disorder.

As a new element to the CIR annual report, beginning in 2014, the causes of death for the population supported as captured in CIRs is compared with the causes of death of all people throughout the state.

2012-2016 Cause of Death

Statewide and Provider Causes of Death 2016

This chart represents in the outer circle, 7,838 deaths statewide.
In the inner circle, 48 provider mortalities are alighed with the statewide causes of death.

The proportion of Cardiovascular and Other types of reports are comparable to statewide data trends. According to statewide data, Cancer and Accidents appear to occur less frequently in the population supported. More frequently appears the Respiratory category. The Respiratory trend was first noted in 2014. Further data analysis years will need to be completed to help analyze trends in this data. The Other category, however, is more prevalent for CIR data than Statewide data with the Therap system it is likely we will have an enhanced classification for trend analysis of causes of death.

SYSTEMS IMPROVEMENTS IN 2017

The CIR process is an important and continuous aspect of DDDs' quality management system. Thorough review of the data and substantive dialogue with a variety of stakeholders resulted in a number of planned systems improvements. One of the primary functions of this annual report is to provide interested parties with a summary of planned systems improvements. They are as follows:

1. The CIR/QA team will informally survey how the annual report information is utilized by providers and what data analysis would be most beneficial in the future as well as the format of the document;

2. The DDD CHOICES Waive Administrator will share CIR data on a quarterly basis with the Internal Waiver Review Committee (IWRC) who will review and provide recommendations to the CIR/QA team and DDD Director;

3. The CIR/QA team will continue to provide formal and informal training at least annually to providers and DDD staff to promote consistency and sound data collection. These training opportunities will be tracked by the CIR team;

4. Program Specialists will conduct technical assistance with providers as needed or requested regarding clarification for CIR Guidelines and reporting expectations as well as changes to the system;

5. Training to providers on and an analysis of provision of training on ANE in an accessible format to participants, families, guardians, and advocates will continue;

6. Partnerships with MFCU and mandatory reporting agencies will be on-going, and further trainings to stakeholders will be held;

7. On-going training with the comprehensive CIR reporting system, Therap, will be on-going, including the maintenance of the CIR/GER Guides;

8. Reports on Jeopardizing Services and Increases in Behavior will continue to be reported to the Clinical Administrator within DDD to help with preparation for other related service needs;

9. CIR/QA team will provide information to a variety of stakeholders regarding current incident review practices and findings of the 2016 CIR Report. Input will be sought from the group regarding any recommendations for incident system improvement;

10. The method in which total population supported is ran for this report will be synthesized with that which Budget and Finance, DHS, utilizes to ensure the duplication of participants due to transfers is minimized and counts increase in accuracy; and

The goal of these system improvements is to increase the overall quality of services and supports for people with intellectual and developmental disabilities in South Dakota.

Please direct any comments and questions about this report to Ashley Schlichenmayer-Okroi, Program Specialist, at Ashley.Schlichenmayerokroi@state.sd.us. Phone contact can be made with Ashley at 605-773-3438.

Website		http://dhs.sd.gov/dd/
Facebook		https://www.facebook.com/S.D.DepartmentOfHumanServices
Twitter		https://twitter.com/SDHumanServices