

Critical Incident Reporting

2015 Trend Analysis



Prepared by the Critical Incident Reporting Team

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The tenth annual Critical Incident Report (CIR) Trend Analysis provides a summary review of the data submitted by the nineteen Community Support Providers (CSPs) and one private Intermittent Care Facility for Intellectual and Developmental Disabilities (ICF/IID) which is aggregated for calendar year 2015. The Division of Developmental Disabilities' (DDD's) intent is to issue a comprehensive trend analysis on an annual basis while providing specific reports to each CSP 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 2015:

- ◇ 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



- ◇ **2,858 participants are on CHOICES HCBS Waiver, CTS, or Private ICF in 2015.**
- ◇ **The 2015 CIR Annual Report is the tenth annual of said report issued by DDD.**
- ◇ **In these ten years, 14,264 CIRs have been reviewed.**
- ◇ **Collaboration with the Medicaid Fraud Control Unit and the Department of Social Services Adult Services and Aging is on-going.**



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.

2015 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 Waiver¹, 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 request further information or follow-up related to the critical incident.

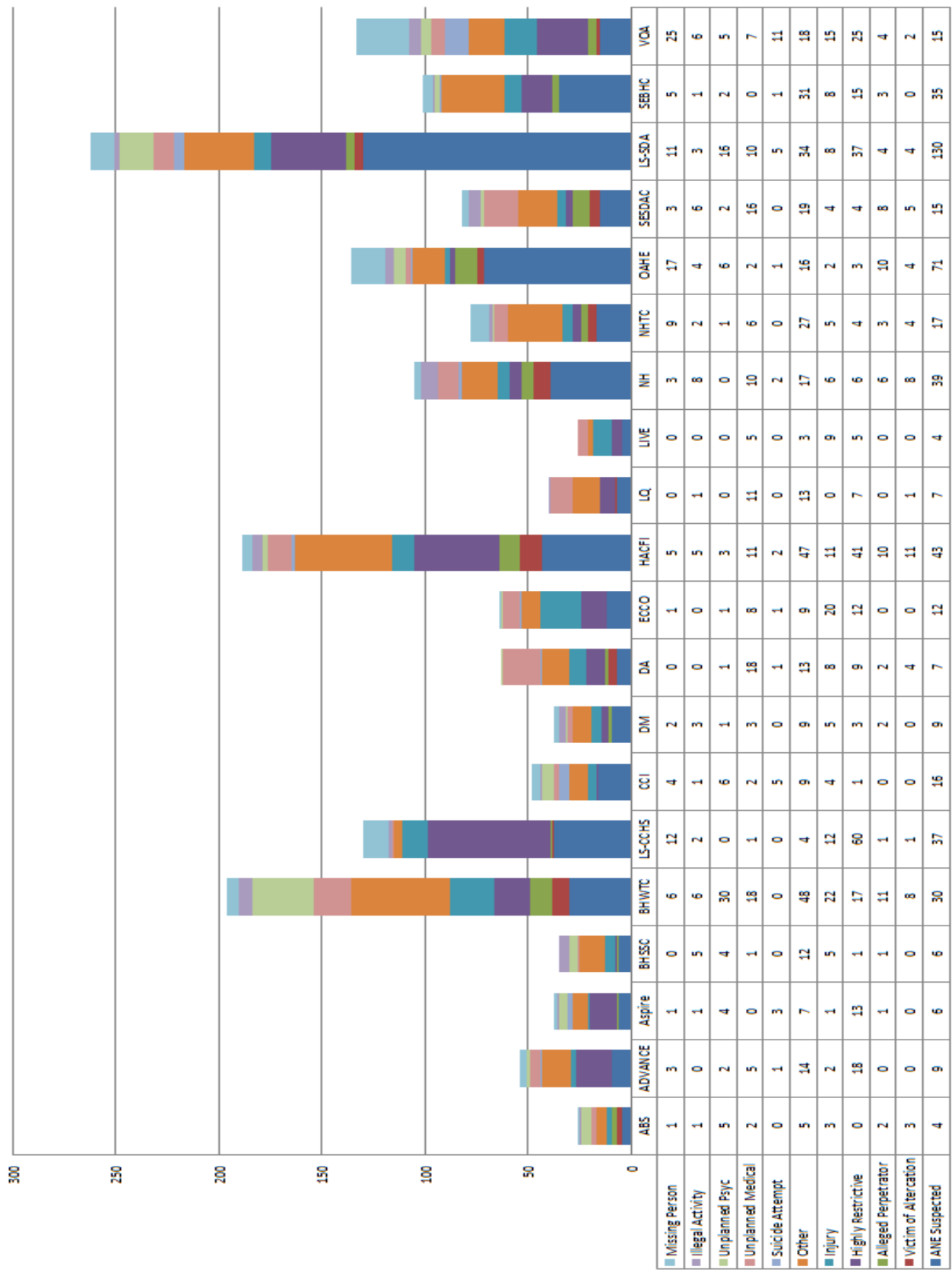
The provider shall notify the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, that a critical incident report has been submitted and the reason why unless the parent or guardian is accused of the incident.

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.

2015 Incident Totals by CSP



This chart captures data on all 2015 CIRs by provider organization.

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, Department of Social Services) 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 2015

- 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 and Department of Social Services Adult Services and Aging (DSS/ASA) occurred on an on-going basis this year.
- 3) Program Specialists conducted technical assistance with seven 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) Work began on selecting an online CIR reporting system as the transition to Conflict Free Case Management occurs in 2016.
- 6) A survey was sent to all CSPs to gain feedback related to use and application of the CIR Annual Report by each provider. Specific questions were asked clarifying if CSP's are finding the reports useful, which sections are most valuable, and if the report aids organizations in strategic planning.
- 7) Participation by the CIR Lead in the South Dakota Elder Abuse Task Force created by Senate Bill 168 passed during the 2015 Legislative Session occurred. A final report was issued as a result of these efforts.
- 8) The 2015 CIR Report contains information on Systemic Monitoring and Reporting Technology (SMART), National Core Indicators, and Council on Quality and Leadership data to address systemic trending for Critical Incidents. More information on each entity is found further within this report.

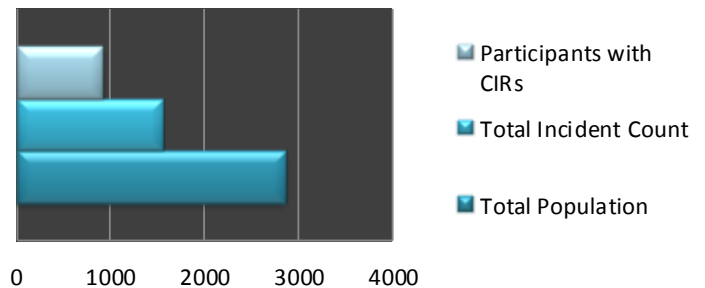
Total Numbers of Incidents

In 2015, the number of persons supported through HCBS, CTS and private ICF/IID funding increased by 9, and the number of participants for whom critical incidents were reported also increased by 138 participants from 2014.

The total incident count for 2015 was 1,555 which is an increase of 98 incidents from the previous year.

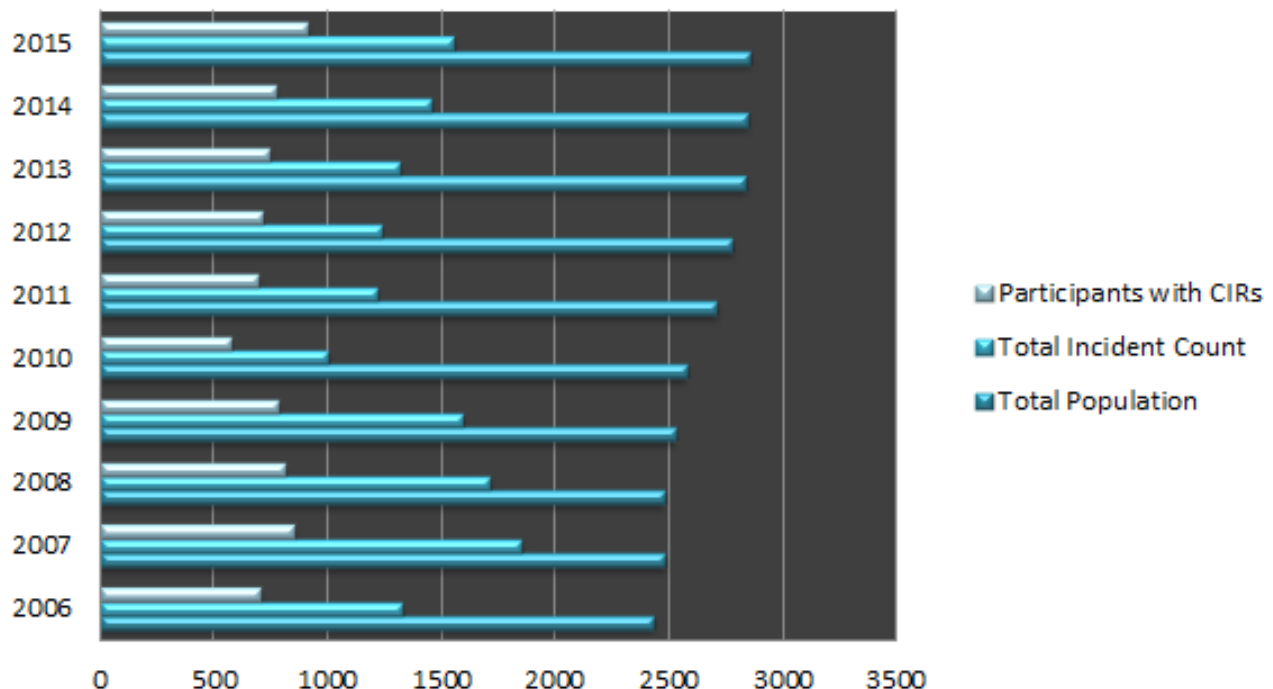
These incidents were submitted for 916 participants, or 58.91% of all participants in South Dakota receiving supports and services through CHOICES, CTS or Private ICF/IID.

2015 Total Number of Incidents



The total population supported has increased overall in the past six years. Although there was an increase in incidents in 2015, this may be attributed to the fact that the number of participants has increased, as well as the trend that providers are supporting people with more challenging needs in least restrictive settings. Therefore, multiple CIRs are reported for those people.

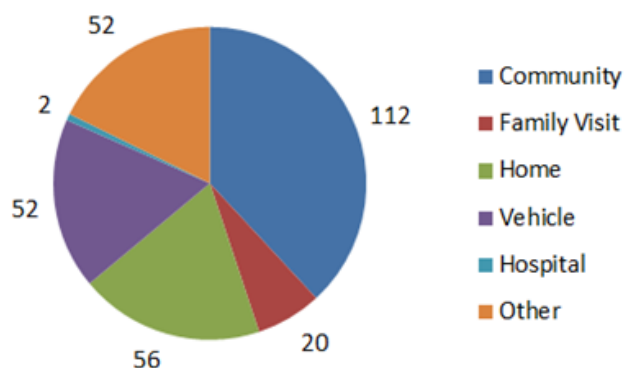
2006-2015 Total Number of Incidents



	Total Population	Total Incident Count	Participants with CIRs	% of Participants with CIRs
2006	2434	1322	708	29.09%
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%

The table above reflects the fluctuation in population, incident count, and number of participants for whom CIRs were reported. 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.

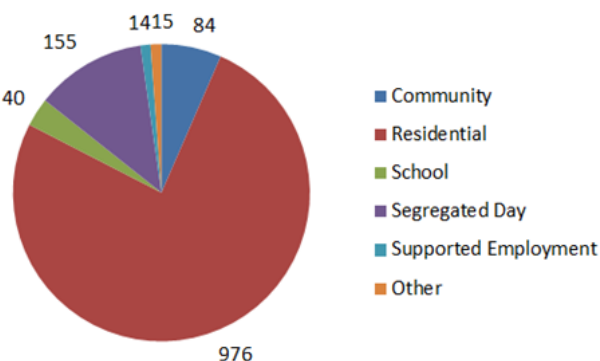
2015 Location Not in Provider Support



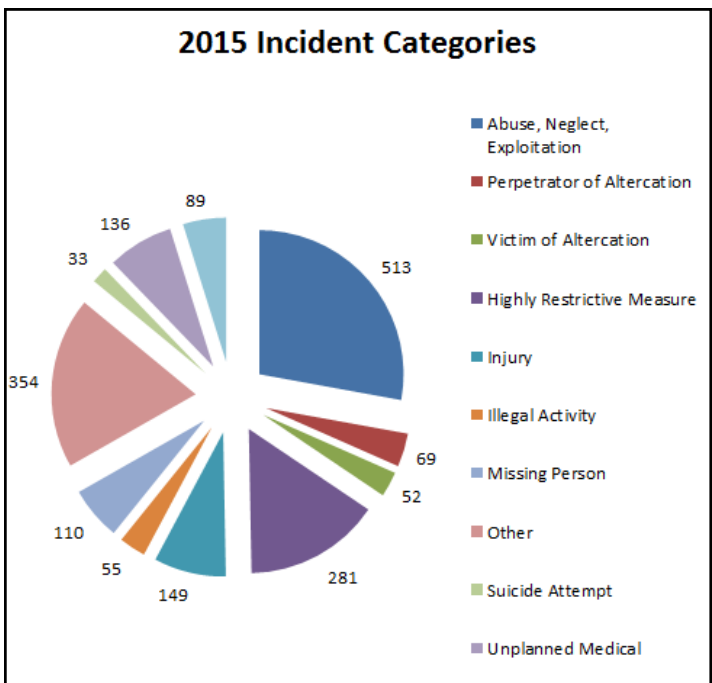
Incidents which occur while people are outside of provider support happen most frequently in the community with 112 reports. This data reflects that participants are accessing the community by themselves or with natural support networks and includes a variety of locations. Fifty-six incidents occurred 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-two incidents occurred at "other" locations, which include, but are not limited 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 environments. Residential settings had 976 reported incidents and segregated day settings had 155 reported incidents. Significantly fewer incidents occur while participants are at other locations in the community, supported employment, school, and in vehicles. The data may also indicate that incidents 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.

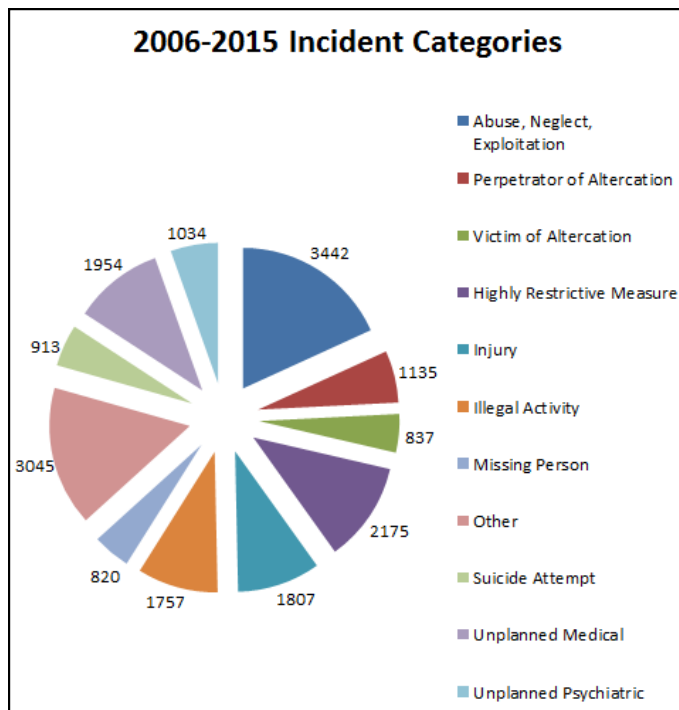
2015 Location in Supports



In 2015, the CIR category most frequently reported to DDD was Abuse, Neglect and Exploitation (ANE) with 513 incidents. This is an increase of 10 reports from the previous year's data. The second highest category reported was Other with 354 incidents. This is a change from trends in the past years where the Highly Restrictive Measures category showed 281 incidents (284 reports in 2014) now third likely reported versus the second most reported category in 2014 with 332 incidents. This data shift could be related to efforts set forth for the reduction of highly restrictive measures or the incorporation of restraints in plans. Both would reduce the number of CIRs if a restraint is performed correctly and is in a person's plan which are not reportable as a CIR; however, providers do track this information on an on-going basis. 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 33 reports. The number of incidents in the following categories also reflects a decrease from previous years' data: Victim of Altercation, Injury, Illegal Activity, Suicide Attempt, Unplanned Medical, Missing Persons, and Unplanned Psychiatric categories.



Incident reporting trends for 2006 through 2015 are consistent with 2015 reporting with ANE and Other being the most frequently reported incidents over the past ten years. ANE reporting has ranged from 206 reports in 2006 to 513 reports in 2015 with an average of 344 incidents per year between 2006-2015.

The Other category has a total of 3,045 reports in the ten year span of time. Numbers have been fairly steady with 225 being the lowest in 2010 and 360 being the highest in 2008. This was likely due to the wide variety of areas encompassed by this Other category.

Incidents in the Highly Restrictive Measures category total 2,175 from 2006 through 2015. Reporting in this category has generally increased since 2006 with a decrease in 2015.

QUARTERLY REPORTING

Mean, Median, Mode, and Range

Mean: Average

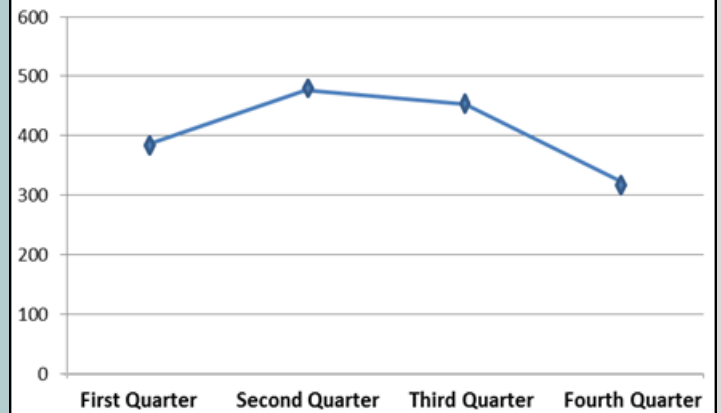
Median: Middle

Mode: Most

Range: biggest - smallest

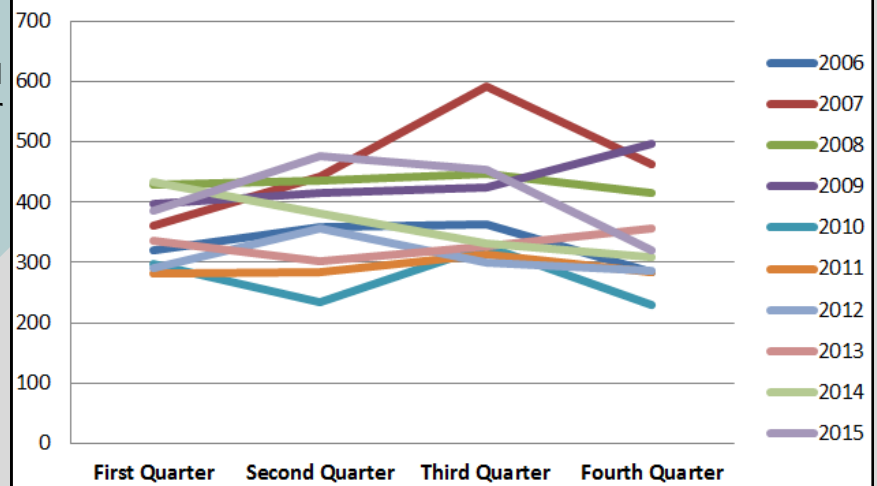
Data for 2015 reflects fairly consistent levels of incident reporting from quarter to quarter.

Quarterly Reporting 2015



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

2006-2015 Quarterly Reporting



Incident counts range from 229 in 2010 to 592 in 2007.

The median value captured is 356 incidents.

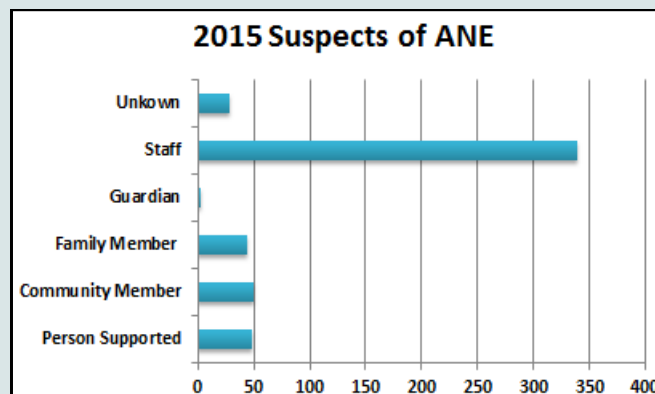
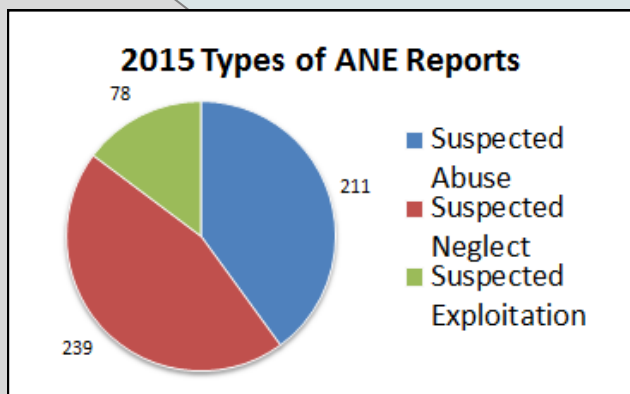
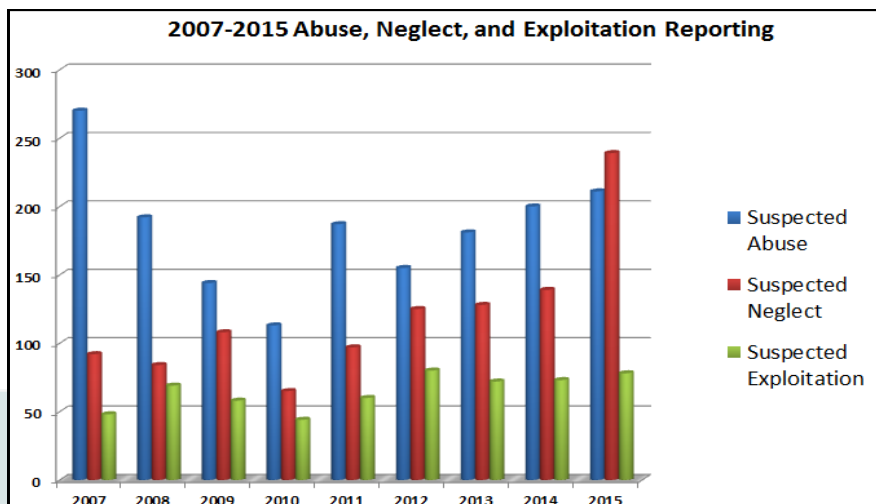
The mean of the data is 363 incidents per quarter.

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
2006	321	359	364	284
2007	360	442	592	462
2008	429	436	448	416
2009	397	416	424	496
2010	298	234	326	229
2011	282	285	313	284
2012	291	356	301	286
2013	337	303	327	356
2014	434	381	332	310
2015	385	477	453	321

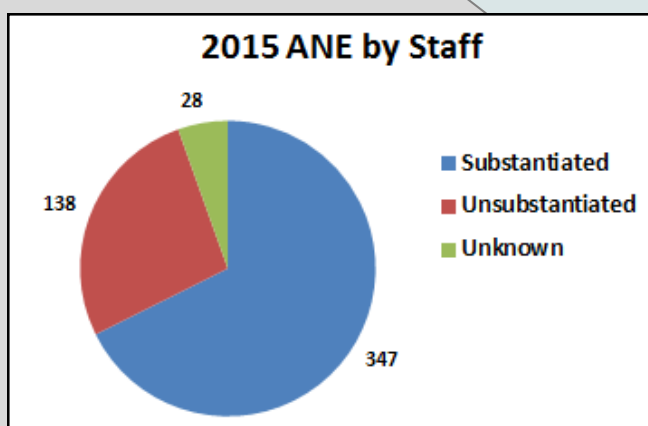
ABUSE, NEGLECT, AND EXPLOITATION

Abuse, Neglect, and Exploitation (ANE) is the highest volume of CIRs reported most frequently across the system. Suspected abuse had been the most frequently reported of the three categories from 2007 up until this past year. In 2015 suspected neglect surpassed suspected abuse as the highest reported type of allegation for the first time by 28 reports. Exploitation has remained fairly steady over these nine data years, however especially so in the past three years with a variance of six reports in those three years.

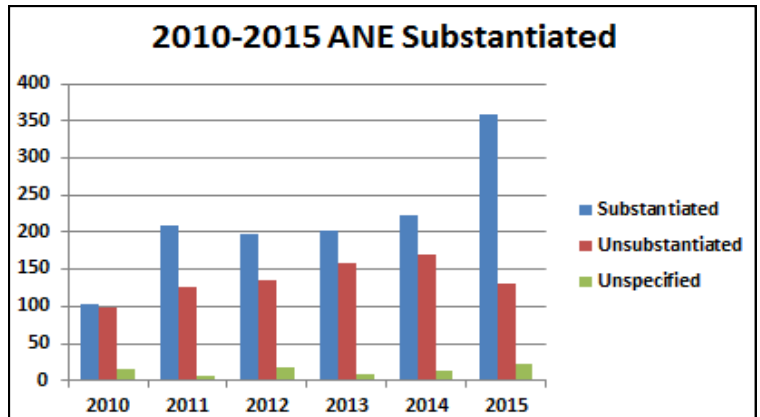
In 2015, incidents of ANE increased by 116 incidents from 2014. Allegations against Community Member and Unknown decreased. All other suspected by categories increased slightly. However incidents in which staff were accused of ANE totaled 339, which is an increase of 94 reports from 2014.



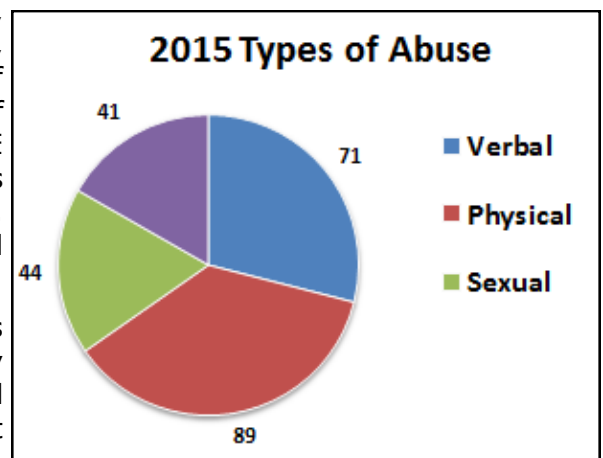
2015 substantiation of ANE by staff reflects that 68% of reports are substantiated by investigations conducted either by the Community Support Provider or external sources such as law enforcement or Social Security.



Data from 2008 to 2015 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 2014 to CSPs regarding these reports and will be repeated in 2016 as 2015 data reflects a higher number of inconclusive investigations than past years.

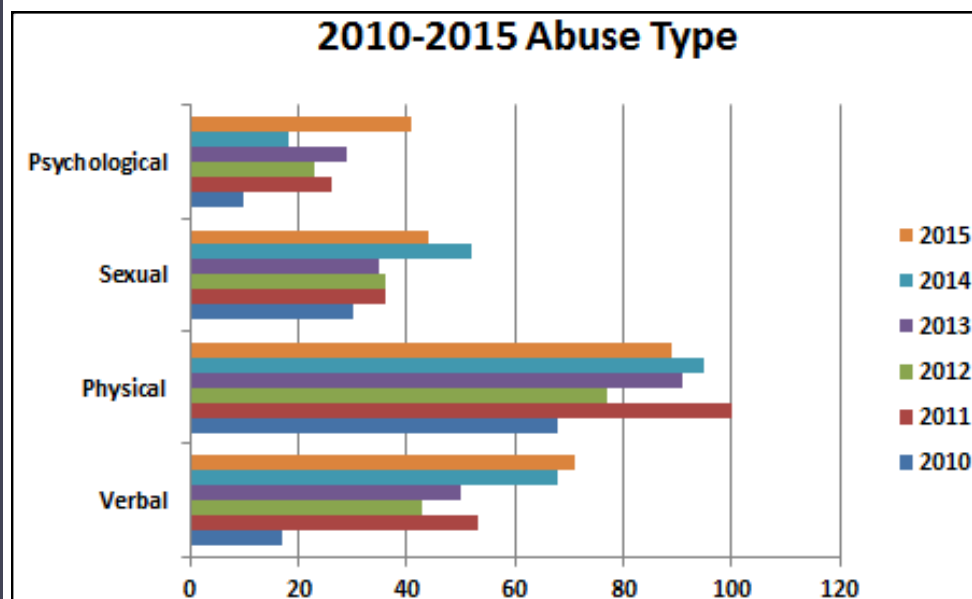


Abuse CIRs are further categorized into Verbal, Physical, Sexual, or Psychological Abuse. In 2015, Physical Abuse was the most frequently reported type of abuse with 89 of the 245 reports. On the prior page of this report, data on Abuse reflects 211 total ANE reports. The explanation for the differing amounts is there are often multiple areas captured in a single CIR. So, both verbal and physical abuse or verbal and sexual abuse often occur in the same incident.



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

Different timeframes are reflected in the cumulative graphs, as over time, changes were made to the data collected.



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.

SMART

Beginning 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 South Dakota Administrative Rules. 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 if warranted.

On a 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. SMART Waiver Assurances is designed to run based on fiscal year so there will be two sets of that data for 2015.

CMS Waiver Assurances and results related to CIRs 01/01/2015–05/31/2015:

% of participants for whom an allegation of ANE was handled appropriately:							
Provider	Total	Total NA	Total Not NA	Total Incorrect	% Incorrect	Total Correct	% Correct
Statewide	78	70	8	2	25.00%	6	75.00%

% of participants for whom critical incidents were handled appropriately:							
Provider	Total	Total NA	Total Not NA	Total Incorrect	% Incorrect	Total Correct	% Correct
Statewide	78	61	17	3	17.65%	14	82.35%

CMS Waiver Assurances and results related to CIRs 06/01/2015–12/31/2015:

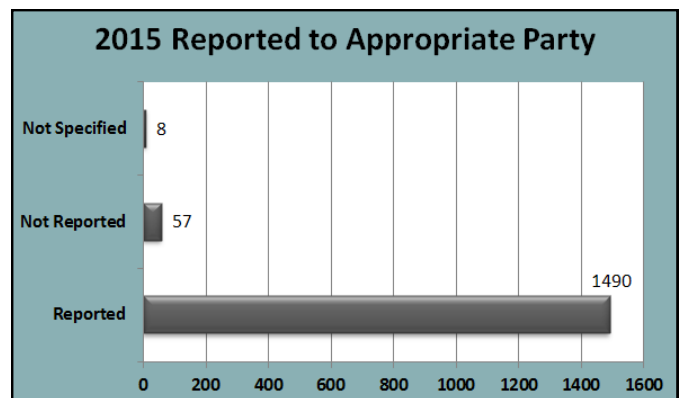
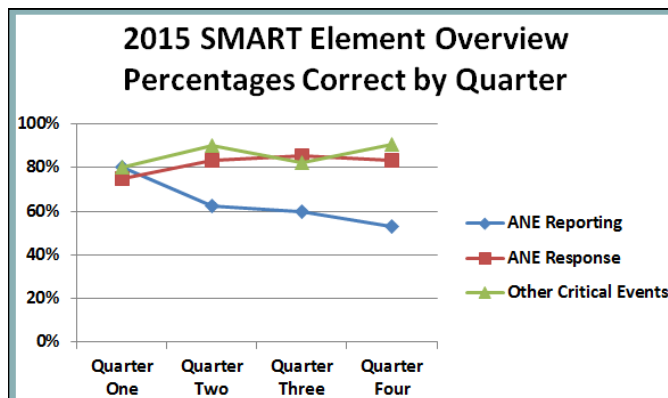
% of participants for whom an allegation of ANE was handled appropriately:							
Provider	Total	Total NA	Total Not NA	Total Incorrect	% Incorrect	Total Correct	% Correct
Statewide	172	145	27	10	37.04%	17	62.96%

% of participants for whom critical incidents were handled appropriately:							
Provider	Total	Total NA	Total Not NA	Total Incorrect	% Incorrect	Total Correct	% Correct
Statewide	172	128	44	5	11.36%	39	88.64%

01/01/2015-12/31/2015 Element Overview Data:

The first table below highlights the SMART data for all 2015 CIRs chosen for representative random sample file reviews. The data is also aligned by quarter in a chart below to the left.

Element	Total	Number NA	Number Incorrect	Percent Incorrect	Number Correct	Percent Correct
ANE Reporting	264	226	15	39.5%	23	60.5%
ANE Response	263	234	5	17.2%	24	82.8%
Other Critical Events	261	198	9	14.3%	54	85.7%



The above chart to the right captures ANE reporting for 2015. Further analysis of the Not Specified areas appear to relate largely to when the suspected perpetrator is accused of the ANE allegation.

ANE REPORTING			
Causal Factor	Factor Count		
No report to parent / guardian	4		
Not identified	3		
Verbal report to DDD not timely	3		
Mandatory reporter - no report	3		
No online report to DDD	2		
No verbal report to DDD	2		
Report to parent / guardian not timely	1		
Online report to DDD not timely	1		
Cases: 250	N/A: 216	Incorrect: 12	Factors: 19

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

ANE RESPONSE			
Causal Factor	Factor Count		
Findings - documentation inadequate	1		
Findings - not distributed	1		
Preventative actions not documented	1		
Cases: 250	N/A: 224	Incorrect: 3	Factors: 3

ANE Response includes information related to findings of investigations and ensuring preventative actions are in place and adequate.

OTHER CRITICAL EVENTS			
Causal Factor	Factor Count		
Not identified	4		
Online report to DDD not timely	2		
No verbal report to DDD	1		
Verbal report to DDD not timely	1		
No online report to DDD	1		
Cases: 250	N/A: 189	Incorrect: 8	Factors: 9

Other Critical Events relates to all other CIRs that are not ANE within the representative random sample file reviews and the reporting of these as outlined in ARSD.

DDD ACTIONS TAKEN:

In 2016, reports will be run indicating all providers at or below the CMS threshold of an 86% rate of compliance, the CMS compliance rate, for ANE Reporting and ANE Response and discussion with providers and technical assistance will be offered. Program Specialists continue to monitor SMART data on a quarterly basis with the CSP.

Also in 2016 Division staff will form small SMART groups so CSP data can be discussed on a regional and more focused basis as well.

In 2016 the transition to Conflict Free Case Management is slated to begin. The 2016 report will contain more information about this transition and CIRs from both CSPs and case management providers.

SIGNIFICANT EVENTS:

During 2015 one CSP was placed on probation related to non-compliance of several ARSD which resulted in the mortality of a participant by suicide. The participant had a behavior support plan and the supports were not provided as outlined in the plan. The organization developed a comprehensive Plan of Correction to remediate each of the findings areas and to ensure that organization-wide these issues were remediated.

Another CSP was required to complete a Plan of Enhancement but retained certification status in relation to several ARSD with which the CSP was found to be in non-compliance. This situation was discovered as a result of a monthly SMART file review.

At the end of 2015, both CSPs continued to work on their respective plans which were anticipated to extend into 2016 before the plans were completed.

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

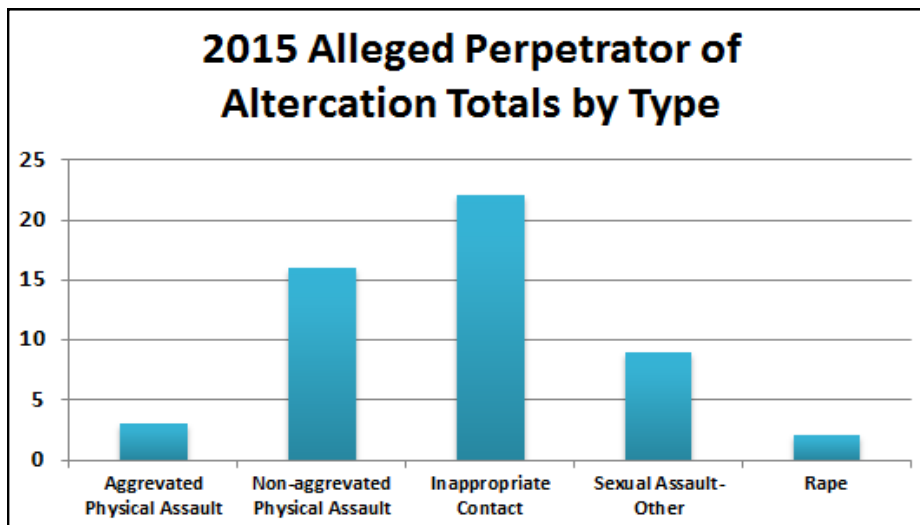
SDCL 22-46-7: Requires that reports of abuse, neglect, or exploitation be made to the State's Attorney's Office, the Department of Social Services, or to law enforcement. Reports must be made within 24 hours.



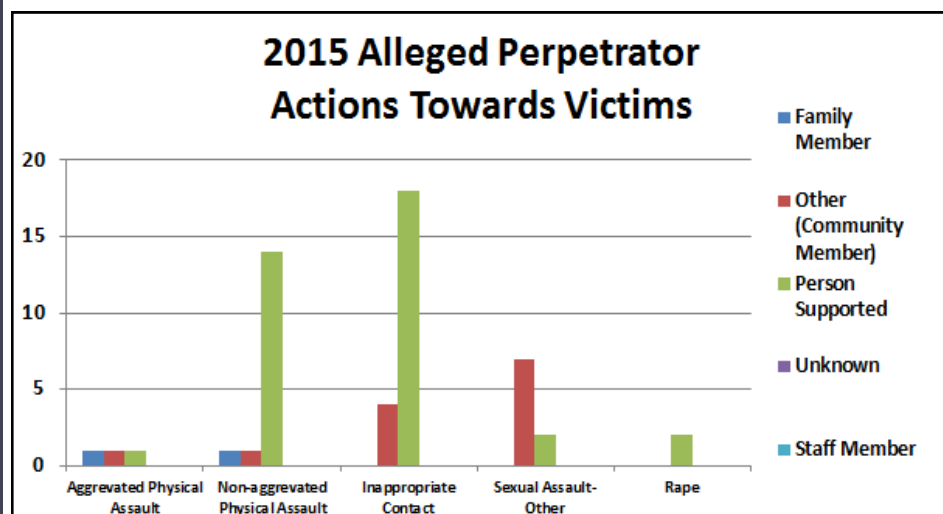
ALLEGED PERPRETRATORS OF ALTERCATIONS

The information below indicates that there were 30 incidents in which a participant was the Alleged Perpetrator of Non-aggravated Physical Assault, 21 incidents of Inappropriate Contact allegations, eight Aggravated Physical Assault allegations, two Sexual Assault-Other allegations, and one incident where participants were accused of Rape. Inappropriate contact increased by five reports from the year prior while Non-aggravated Physical Assault increased by twenty two.

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.



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.



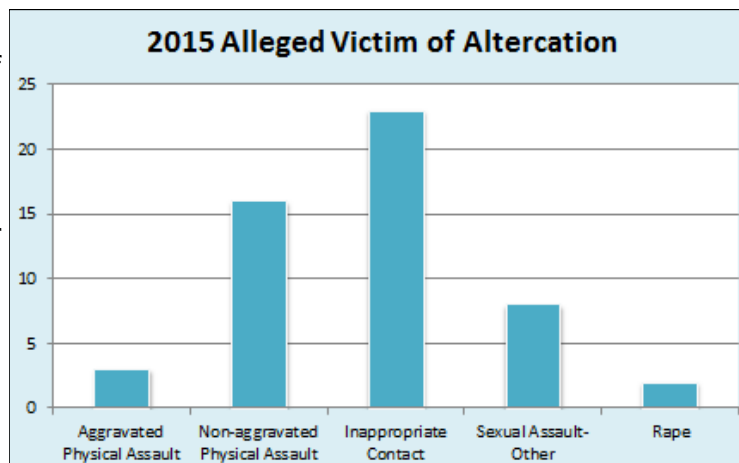
The chart at left demonstrates the victims for each type of altercation under the Alleged Perpetrator section of the online CIR form. Reports for People Supported are the highest in all categories, followed by staff member and community member or other.

ALLEGED VICTIMS OF ALTERCATIONS

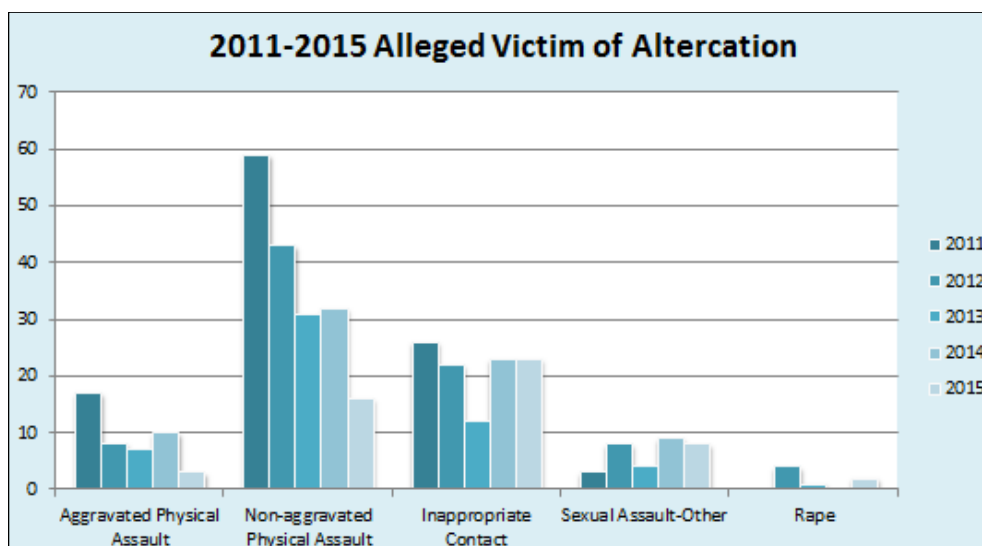
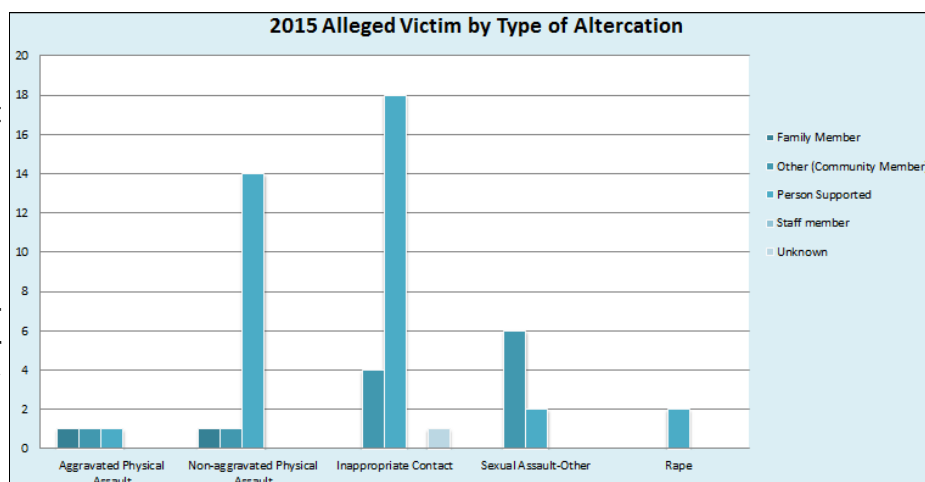
The next page demonstrates who the perpetrators were for each type of altercation under the Alleged Victim section of the online CIR form.

ALLEGED VICTIMS OF ALTERCATIONS

In 2015 there were 53 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, (such as typical crimes like 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 2 participants resulting in an injury.



Inappropriate contact occurred in both 2014 and 2015 23 times. Non-aggravated physical assault decreased in 2015 from 32 to 16 reports. Aggravated physical assault also decreased from 10 reports in 2014 to 3 in 2015. There were 2 victims of rape in 2015 although none in the year past. Sexual Assault-Other occurred at the same frequency of 9 in 2015 as 2014.

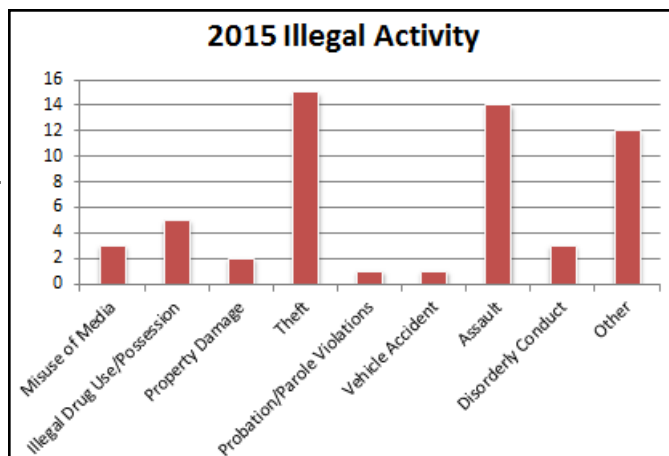


Victims of Altercations were largely represented by other persons served with 37 total incidents in that category; 13 incidents were committed by community members. The remaining 3 reports involved unknown perpetrators such as family. Perpetrators of Altercations in 2015 did not include staff largely because these incidents would typically be captured as abuse in the ANE category.

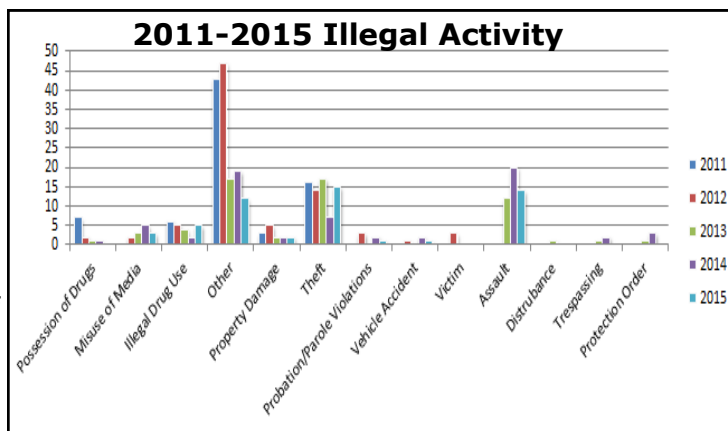
Incidents in the CIR system need to be entered as either victims of altercations or abuse except in very rare situations as to count the data on one incident in two areas would be duplicative. DDD offered technical assistance to stakeholders in 2015 on this requirement.

ILLEGAL ACTIVITY

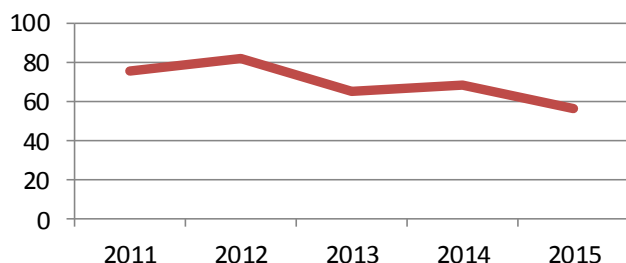
Illegal Activity incidents reported in 2014 totaled 56; 15 of these reports being identified under the category of Theft which doubled from 2014, 14 for Assault which demonstrates a decrease from 20 in relation to 2014 data, and 12 Other reports which is down from 19 in 2014. All other areas remained consistent from 2014.



Annual report analysis of the Other category in 2014 included information indicating the increase in alcohol-related crimes which should be addressed by the CIR team. With the Conflict Free Case Management changes coming in 2016 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.



Illegal Activity 2011-2015



The chart at left demonstrates the steady decrease of illegal activity from 2011-2015. 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 report 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 2,858 people receiving services in South Dakota. The chart below reflects the *Total Number of People Served who may be involved in multiple Illegal Activities:



	Total # of People Served Involved	Illegal Drug Use/Possession	Misuse of Media	Property Damage	Disorderly Contact	Theft	Assault	Disturbance	Trespassing	Other
* CSP	49	5	3	2	3	15	14	0	0	7
* Statewide	46202	7157	185	5320	2324	14260	8194	554	1051	7157

With the 2015 report, a comparison of state-wide crimes committed by all people in South Dakota with the CSP population has been completed.

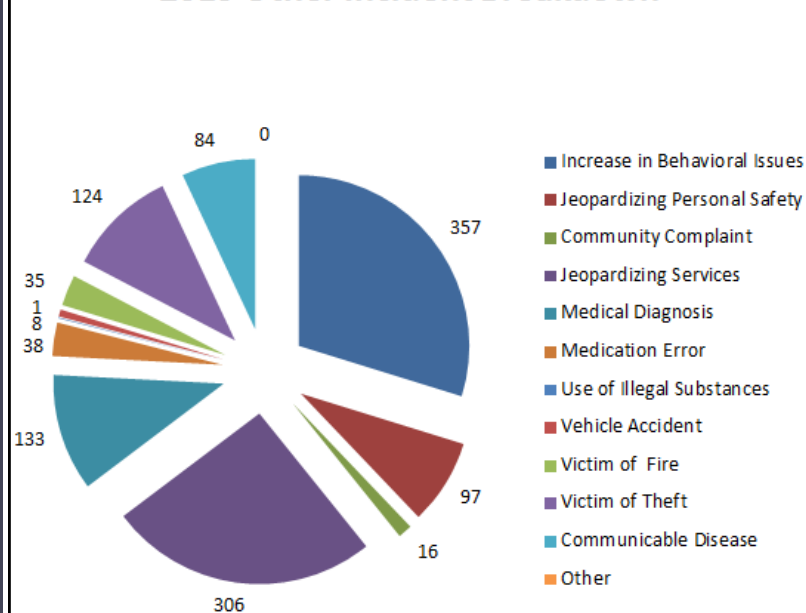
The nine types of crimes on page 21 were aligned with statewide data. Overall, there were 71,046 crimes in the statewide system. These nine areas comprise 46,202 of those. In the CSP system areas were consolidated to align with those nine and some removed which had little data or were not included as crime types in categories A or B in the statewide system.

The source for this data is in the *2015 Crime In South Dakota* report by the office of the Attorney General of South Dakota.

OTHER INCIDENTS

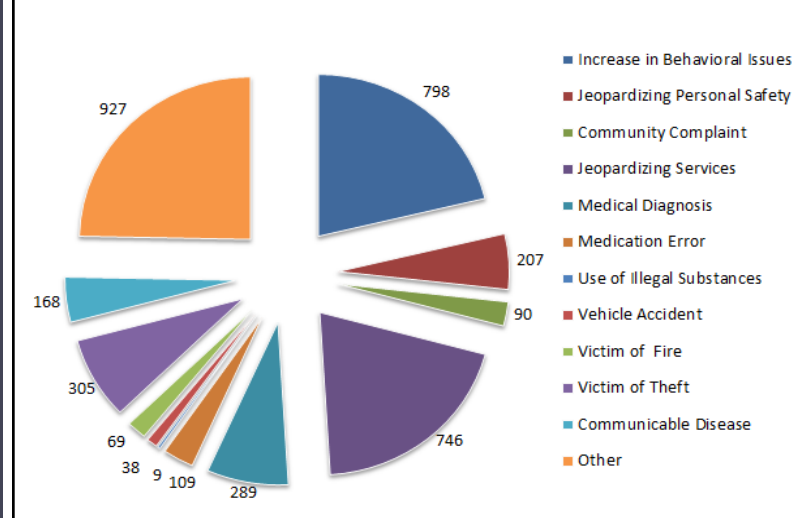
There were 308 CIRs which fell into the "Other" incident category during 2015. These included reports ranging from Communicable Disease to Victim of Theft.

2015 Other Incident Breakdown



Of the total number, all values compare to the 2014 report with the exceptions of Communicable Disease which rose from 21 to 57. This can be attributed to Influenza and a rise in sexually transmitted diseases. Also, there is an increase in Victim of Theft with 57 reports compared to 18. It is believed this is likely due to the training on exploitation versus theft and that theft statewide is prevalent (see data on the previous page). 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.

2006 - 2015 Other Incident Breakdown



Police Involvement with no arrest or charges would be included in the Other category.

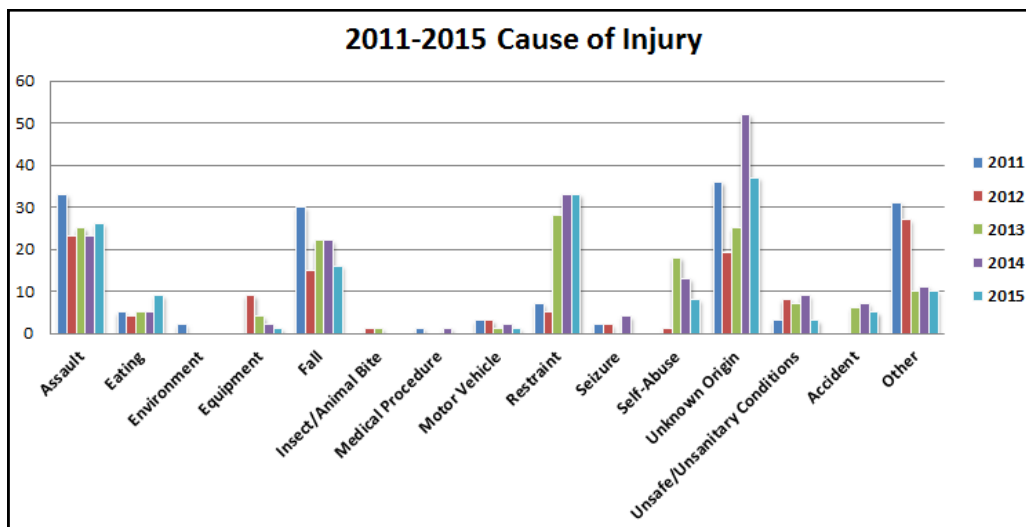
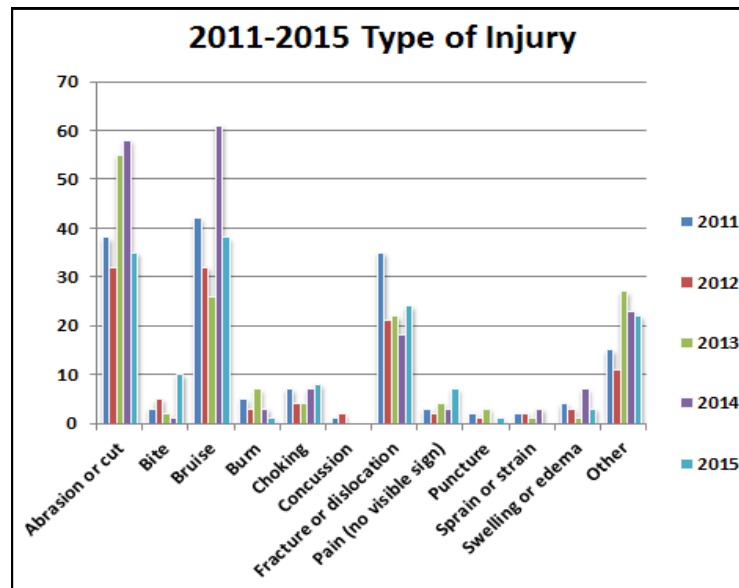
The graph at left shows data from 2006-2015 for each of the incident reporting categories under Other.

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 in 2016 should be of benefit to this data as well.

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 149 injuries reported to DDD compared to 2014 with 184 reports. From 2011-2015, the leading types of injury are consistent with the 2015 data which appears in the chart below with data labels. There were increases in fracture or dislocation and choking but decreases in abrasion or cut and swelling or edema. From 2011-2015, the leading causes and types of injuries have remained consistent.

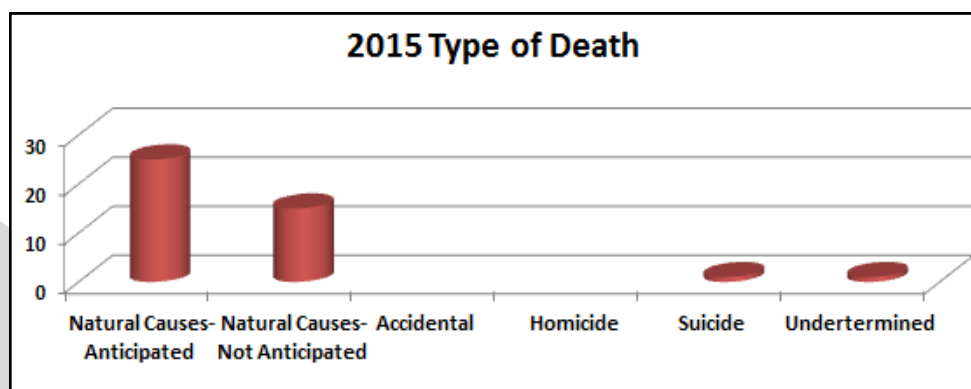
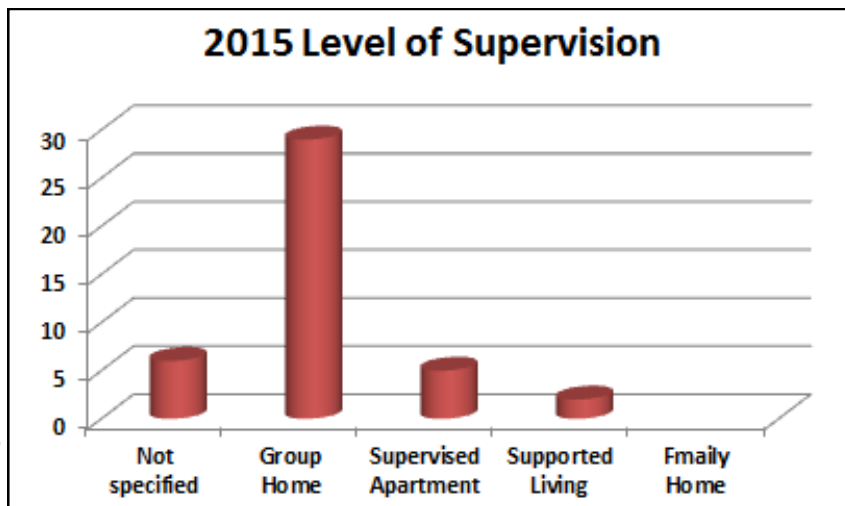


MORTALITY ANALYSIS:

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 2015, 42 death reports were submitted by CSPs.

MORTALITY ANALYSIS CONTINUED:

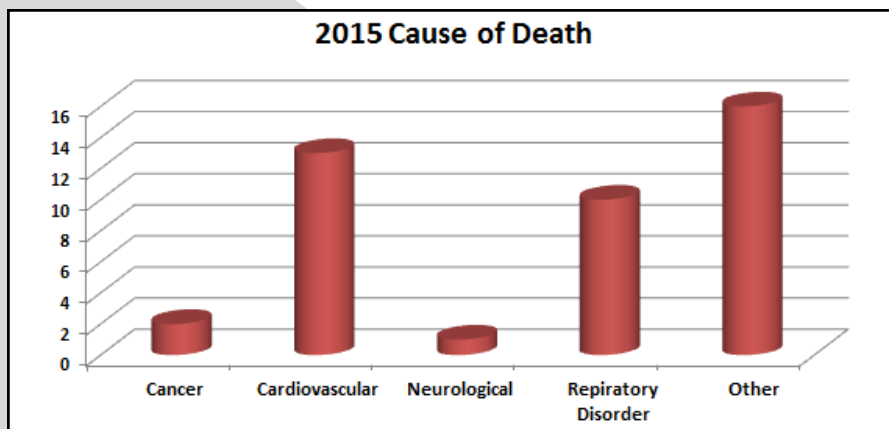
2015 data shows is an increase of 10 deaths from 2014. Of these, 29 participants were receiving residential supports in a Group Home, 5 in each Supervised Apartment, and two in Supported Living settings. Instances in which the level of supervision is "Not Specified" indicates the participant did not receive residential supports from the CSP but received at least one other waiver service, CTS, or private funding.

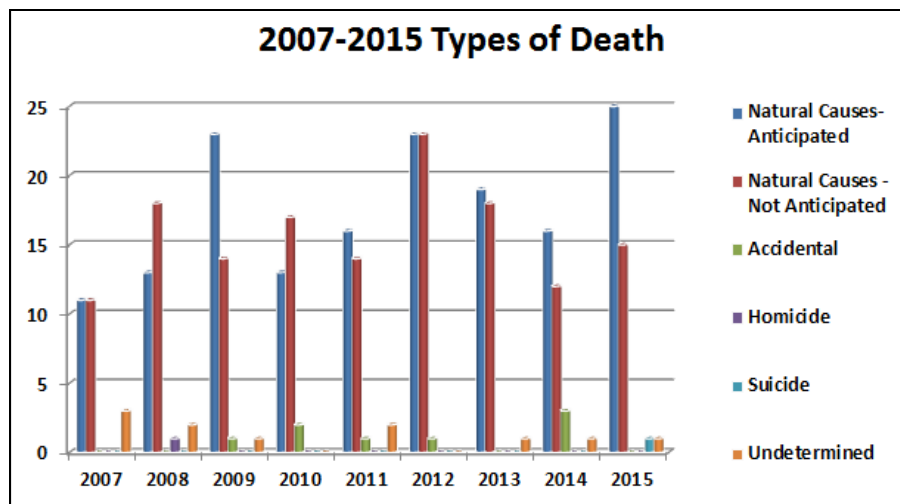


As seen in the graph above, 25 deaths in 2015 were due to Natural Causes-Anticipated and 15 due to Natural Causes-Not Anticipated, 1 Undetermined death, and 1 completion of Suicide. The single Undetermined death was categorized as such due to an inconclusive autopsy report. There were no Homicides reported in 2014.

The leading causes of death in 2015 were Other with 16 reports followed by Cardiovascular at 13 and Respiratory Disorder with 10.

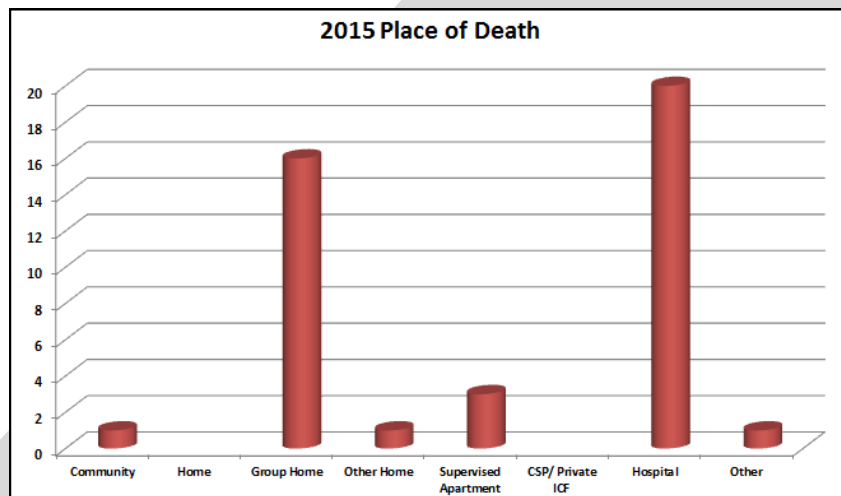
Cardiovascular has increased from zero in 2014 to 13 in 2015. Although this is quite an increase, 13 is comparable to past years. Other is consistent as well reflecting an increase of 2 from 2014. Respiratory remains constant at 10.



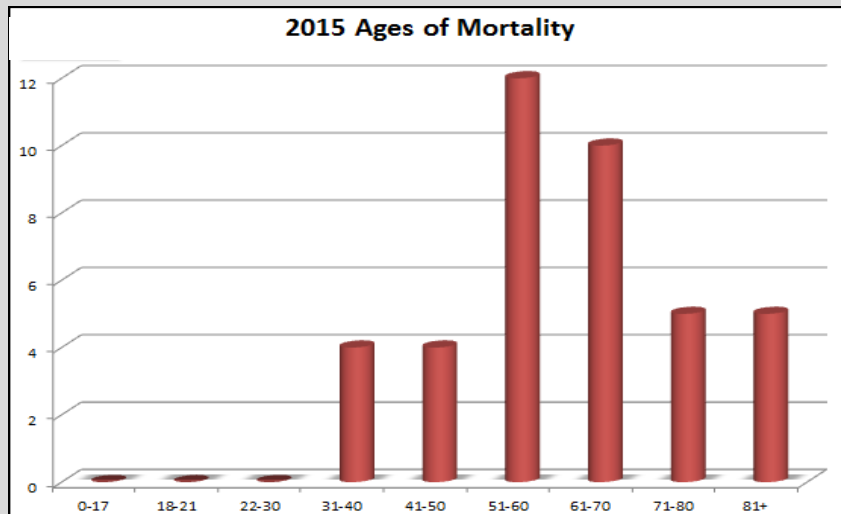


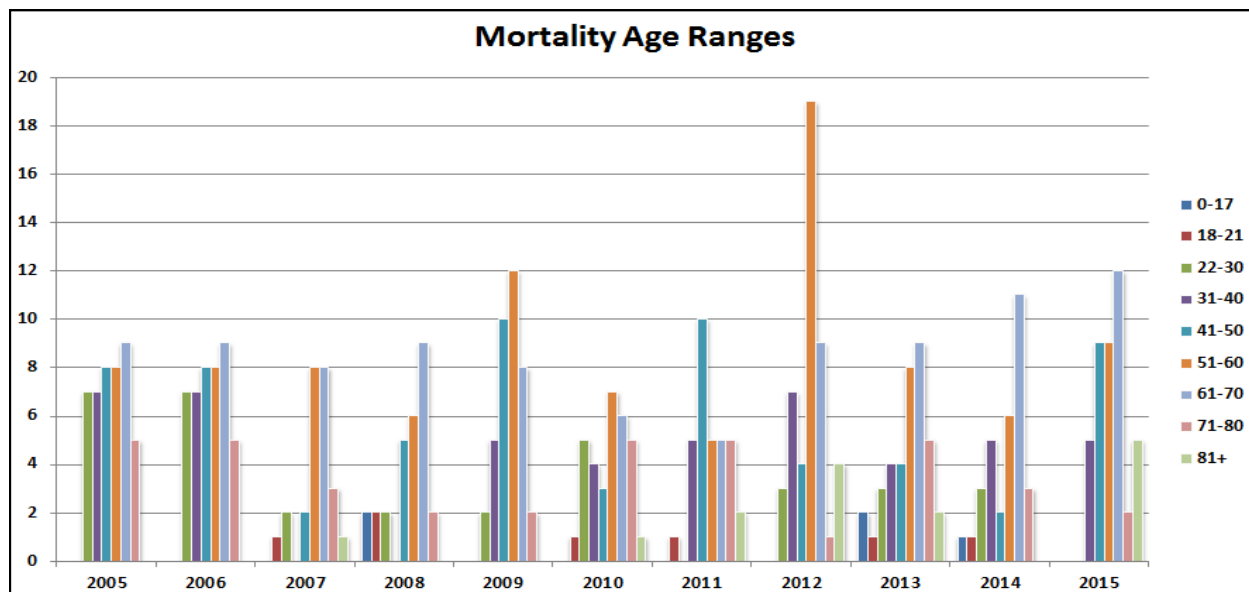
Types of Death reflects a fairly close range of data likely due to the few deaths in the system each year. Participants commonly discharge to hospice or discharge to nursing homes before they pass, so these deaths only account for people who were still receiving services or in the hospital at the time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

As the graph to the right demonstrates, 20 of the 42 incidents of death occurred in a Hospital, 16 occurred at a group home, 3 occurred in Other and community locations, and 3 occurred in a Supervised Apartment.



The graph in this section reflects the number of deaths in each age category. Of the total participant deaths in 2015, 12 died in the 51-60 year old age range in 2015, 10 in 61-70, and 4 in the 31-40 and 41-50 year old ranges. No mortalities occurred for anyone under the age 31 in 2015.

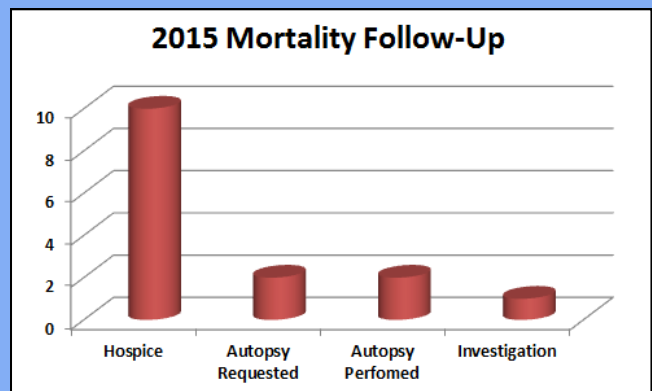




From 2009 through 2015, the ages of death vary, but the curve of each year's data set is fairly consistent with the exception of some years past.

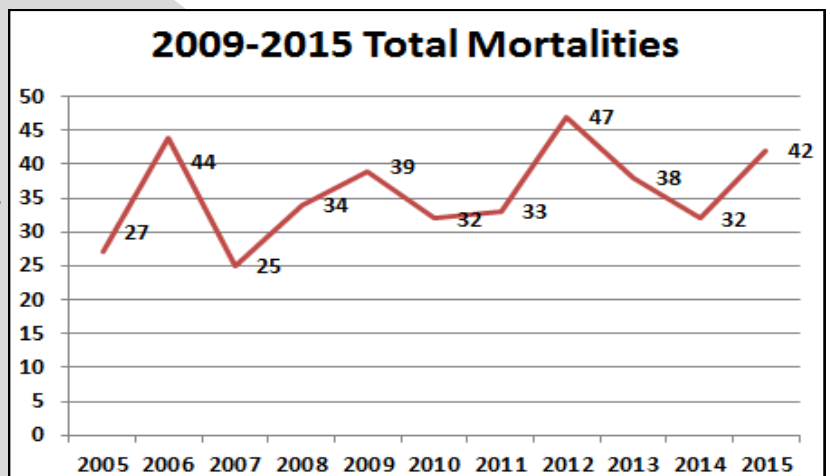
Of the 42 deaths that occurred in 2015, 16 of these were anticipated and hospice care was provided for 8 of the people. Investigations were conducted for 3 separate death reports; 1 on-site investigation was completed by DDD and the others by Law Enforcement.

**See page 17 of this report
for more information
about Significant Events.**

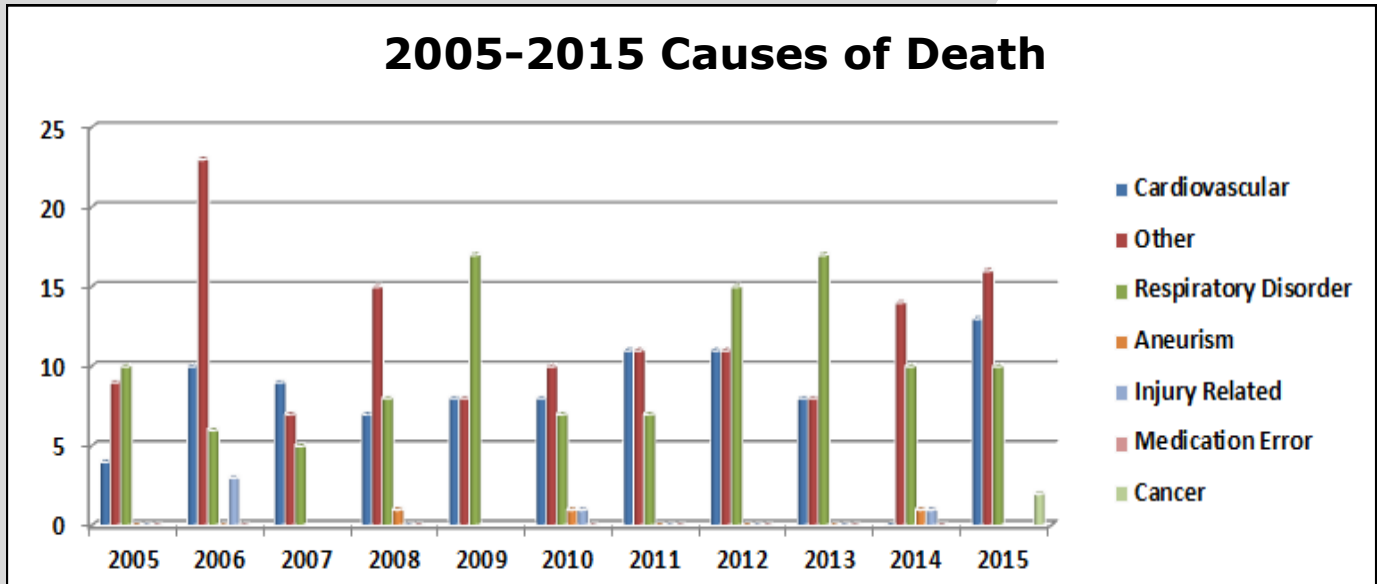


Over the course of the past six years, mortality rates have remained fairly stable. In 2012, the number of deaths increased from the previous years, and had continued to decrease each year until 2014.

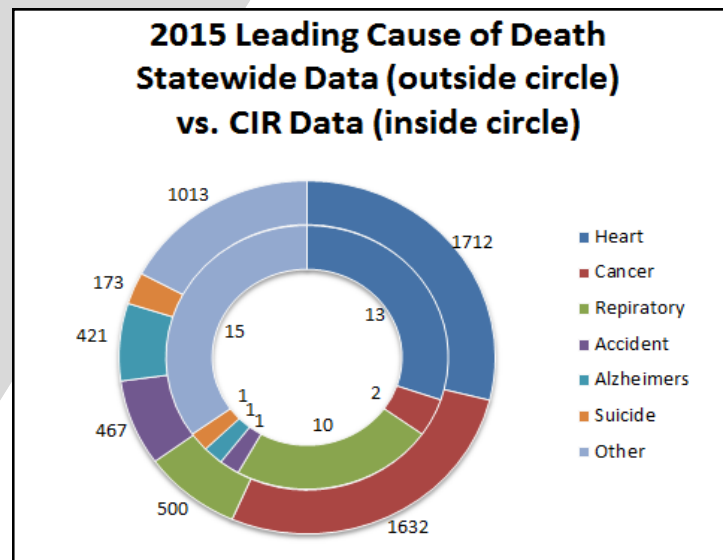
In 2015 data rose again. This may be a result of efforts to support participants for longer at their homes.



The leading causes of death from 2005-2015 are Cardiovascular, followed by Other, Respiratory Disorder.



As a new element to the CIR annual report 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.



The proportion of Cardiovascular, Alzheimer's, and Suicide are comparable within the CIR data for participants and the statewide data. According to statewide data, Cancer and accidents occur less frequently. More frequently appear the Respiratory and Other categories. 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. It is fairly common for families and guardians to not seek autopsies when there are no causes for suspicion within a person's passing, and it appears to be natural causes. So, there are more unknown causes of death which fall into the other category than the overall statewide population supported.

THE COUNCIL ON QUALITY AND LEADERSHIP



South Dakota contracts with The Council on Quality and Leadership (CQL) for accreditation of all CSPs and Case Management (CM) providers. There are several ways CQL assures quality in the accreditation process. All providers within the state are required to be certified with a nationally accrediting organization per ARSD, and annual contracts specify that this organization be CQL.

Basic Assurances®

There are ten factors that need to be in place in order for an organization to achieve or maintain accreditation which appear in the chart to the right.

10 BASIC ASSURANCES® FACTORS

1. Rights Protection and Promotion
2. Dignity and Respect
3. Natural Support Networks
4. Protection from Abuse, Neglect, Mistreatment and Exploitation
5. Best Possible Health
6. Safe Environments
7. Staff Resources and Supports
8. Positive Services and Supports
9. Continuity and Personal Security
10. Basic Assurances® System

Personal Outcome Measures®

21 Outcomes and Supports are determined to be in place, in the process, or not in place based on findings during interviews with participants and those who know them best. DDD began a Personal Outcome Measures® Initiative where representatives from DDD and CSPs were trained and certified as POM Interviewers to be able to collect accurate data. DDD also began funding an additional CQL reviewer during the accreditation visits to gather more data. An online database by CQL is also utilized by DDD.

Important CQL data aligns with CIR data as **3 KEY FACTORS & 21 PERSONAL OUTCOME MEASURES®** Basic Assurances® and Personal Outcome Measures® directly correlate with CIR areas.

PERSONAL:

Starts with the person's own view of his or her life

My Self | *Who I am as a result of my unique heredity, life experiences and decisions.*

- People are connected to natural support networks
- People have intimate relationships
- People are safe
- People have the best possible health
- People exercise rights
- People are treated fairly
- People are free from abuse and neglect
- People experience continuity and security
- People decide when to share personal information

OUTCOME:

Defines what is important to the person

My World | *Where I work, live, socialize, belong or connect.*

- People choose where and with whom they live
- People choose where they work
- People use their environments
- People live in integrated environments
- People interact with other members of the community
- People perform different social roles
- People choose services

MEASURES:

Offers objective determination of whether people are achieving what is personally important

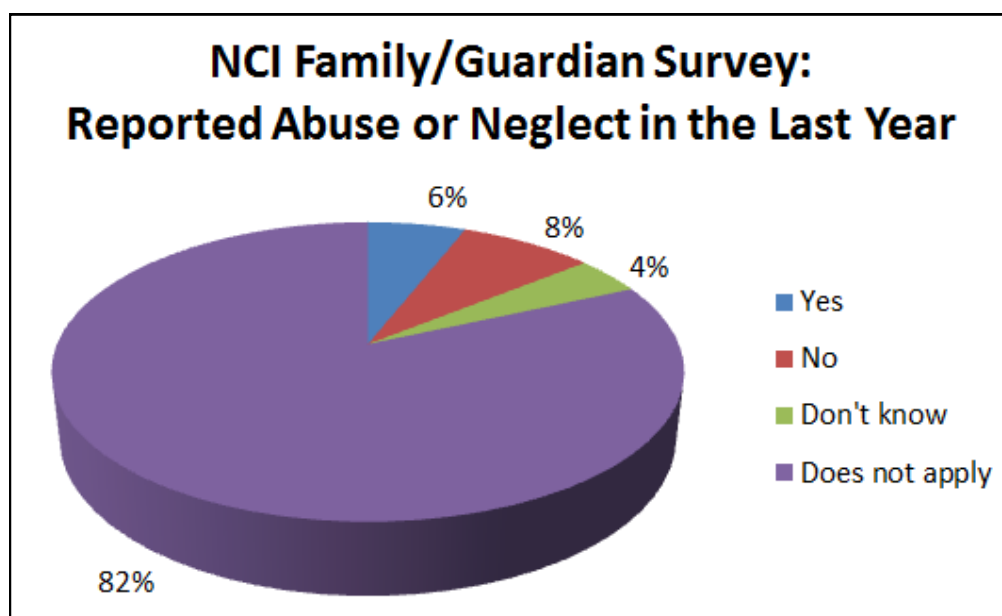
My Dreams | *How I want my life (self and world) to be.*

- People choose personal goals
- People realize personal goals
- People participate in the life of the community
- People have friends
- People are respected

NATIONAL CORE INDICATORS

What is NCI?

The National Core Indicators© (NCI) program is a voluntary effort by state developmental disability agencies to gauge and track their own performance using a common and nationally validated set of performance measures. The effort is coordinated by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) in collaboration with the Human Services Research Institute (HSRI). NCI has developed a set of more than 100 standard performance measures (or "indicators") which states use to assess the outcomes of services provided to individuals and their families. These indicators focus on areas such as employment, rights, service planning, community inclusion, choice, health, and safety. During the 2014-15 data collection cycle, 41 states, the District of Columbia and 22 sub-state entities participated in NCI. Not all participating states complete each NCI surveys every year.



What is contained in this report?

This report illustrates 2014-15 NCI Family/Guardian Survey demographic and outcome results from South Dakota. All results are shown in chart form. Some questions may have a low response rate, particularly questions about knowledge and use of ID/DD money, reporting grievances, and abuse or neglect. States with fewer than 20 responses to a particular question were excluded from analysis for that question. The number of responses per each question by state and across NCI states are included in each chart. All state and national data results for this survey can be found online at <http://www.nationalcoreindicators.org/resources/reports/>.

SYSTEMS IMPROVEMENTS IN 2016

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 survey how the annual report information is utilized by providers and what data analysis would be most beneficial in the future;
2. The DDD CHOICES Waiver Manager 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 DSS will be on-going, and further trainings to stakeholders will be held;
7. DDD is researching the implementation of a new information system which would incorporate CIR reporting allowing for more comprehensive data collection and analysis. It is anticipated for this to go live in 2016;
8. Conflict Free Case Management will be implemented in 2016 which will impact participants and the system significantly. The CIR/QA team will work through issues as they arise with this transition;
9. Reports on Jeopardizing Services and Increases in Behavior will be reported to the Clinical Administrator within DDD to help with preparation for other related service needs;
10. CIR/QA team will provide information to a variety of stakeholders regarding current incident review practices and findings of the 2014 CIR Report. Input will be sought from the group regarding any recommendations for incident system improvement; and
11. Training on substantiation and investigations should be performed in upcoming training opportunities.

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.



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