Office for People With Developmental Disabilities

Justice Center for the Protection of People with Special Needs

SUCCESSFUL STRATEGIES FOR ADDRESSING TRENDS IN OPWDD SETTINGS

New York Alliance for Inclusion & Innovation, Annual Conference, April 15, 2026

Justice Center *Prevention and Quality Improvement,* OPWDD *Division of Quality Improvement*

AGENDA

- **Justice Center**
  - Abuse/Neglect Trends
  - Prevention Resources
- **OPWDD**
  - Significant Incident (SI) and Serious Notable Occurrence (SNO) Trends
  - OPWDD Trend-Informed Resources
  - Strategies for Utilizing OPWDD Resources
  - BPC Survey Trends

PREVENT. PROTECT. ADVOCATE.

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"THE JUSTICE CENTER CREATES A SAFER, MORE INCLUSIVE NEW YORK."

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TRENDS IN ABUSE/NEGLECT CASES

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CATEGORIZATION OF FINDINGS

CATEGORY 1

Serious physical abuse, sexual abuse or other severe conduct by a subject

CATEGORY 2

A subject significantly endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect

CATEGORY 3

Less serious incidents of abuse or neglect. Reports are sealed after five years

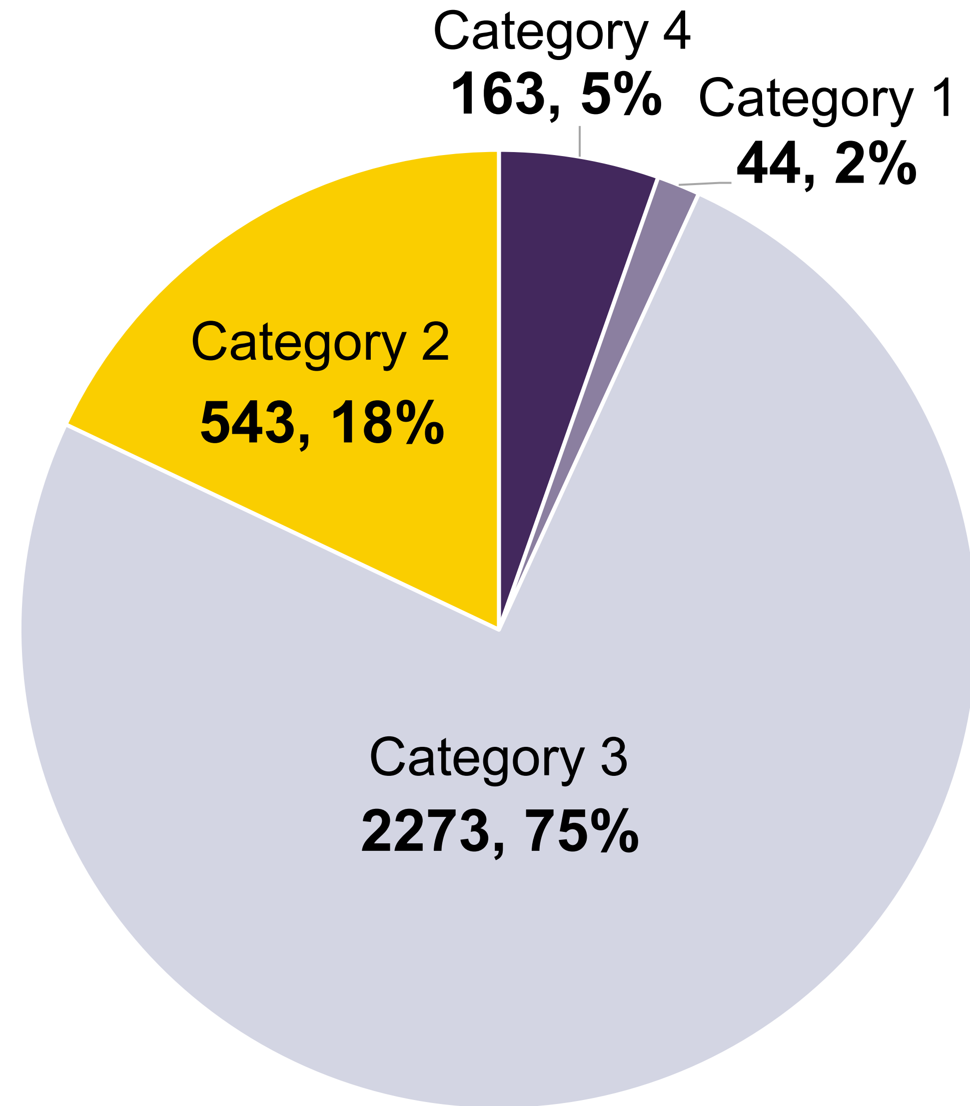
CATEGORY 4 - FACILITY FINDING

Conditions at a program or facility expose people receiving services to harm or risk of harm

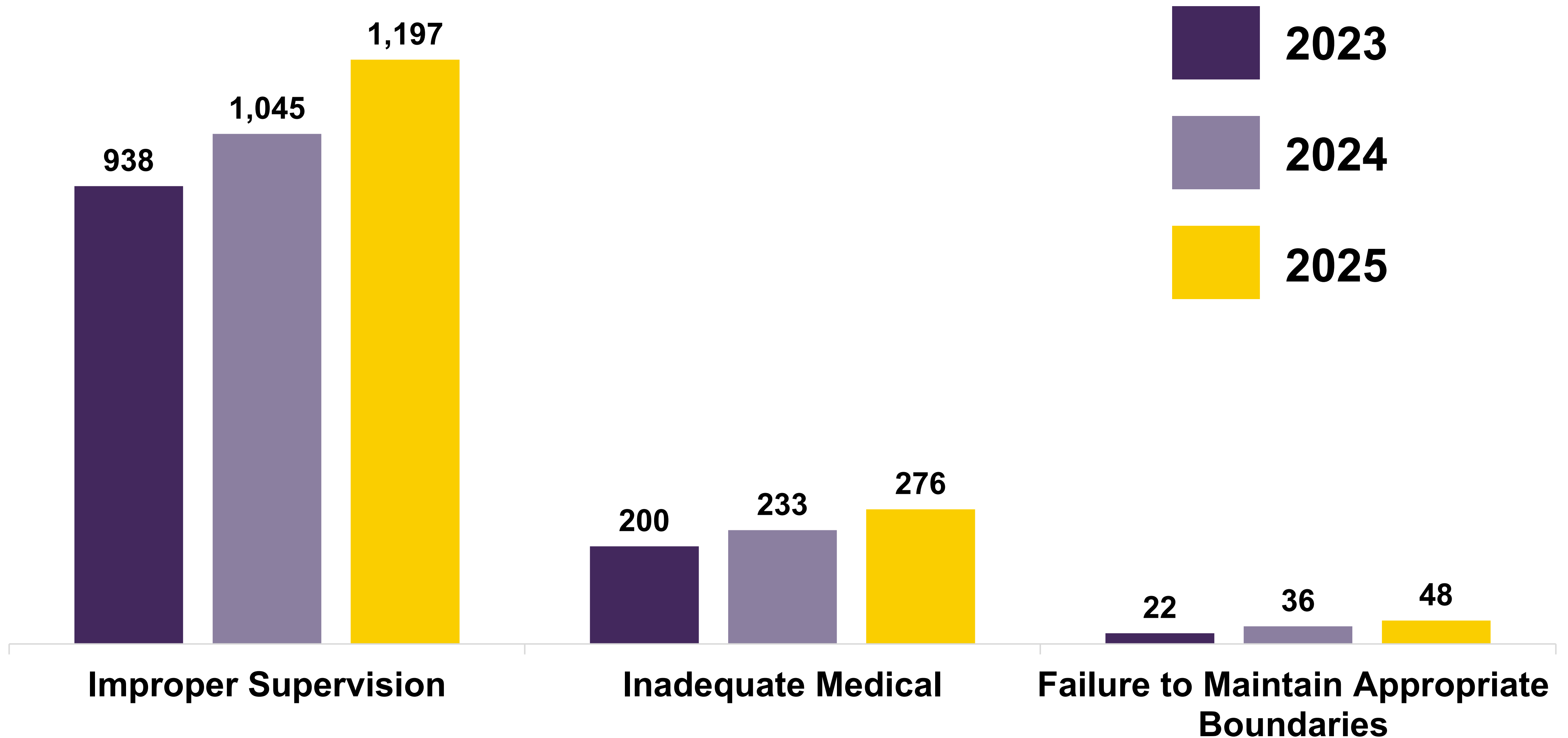
OPWDD 2025 CATEGORIZATION

40%

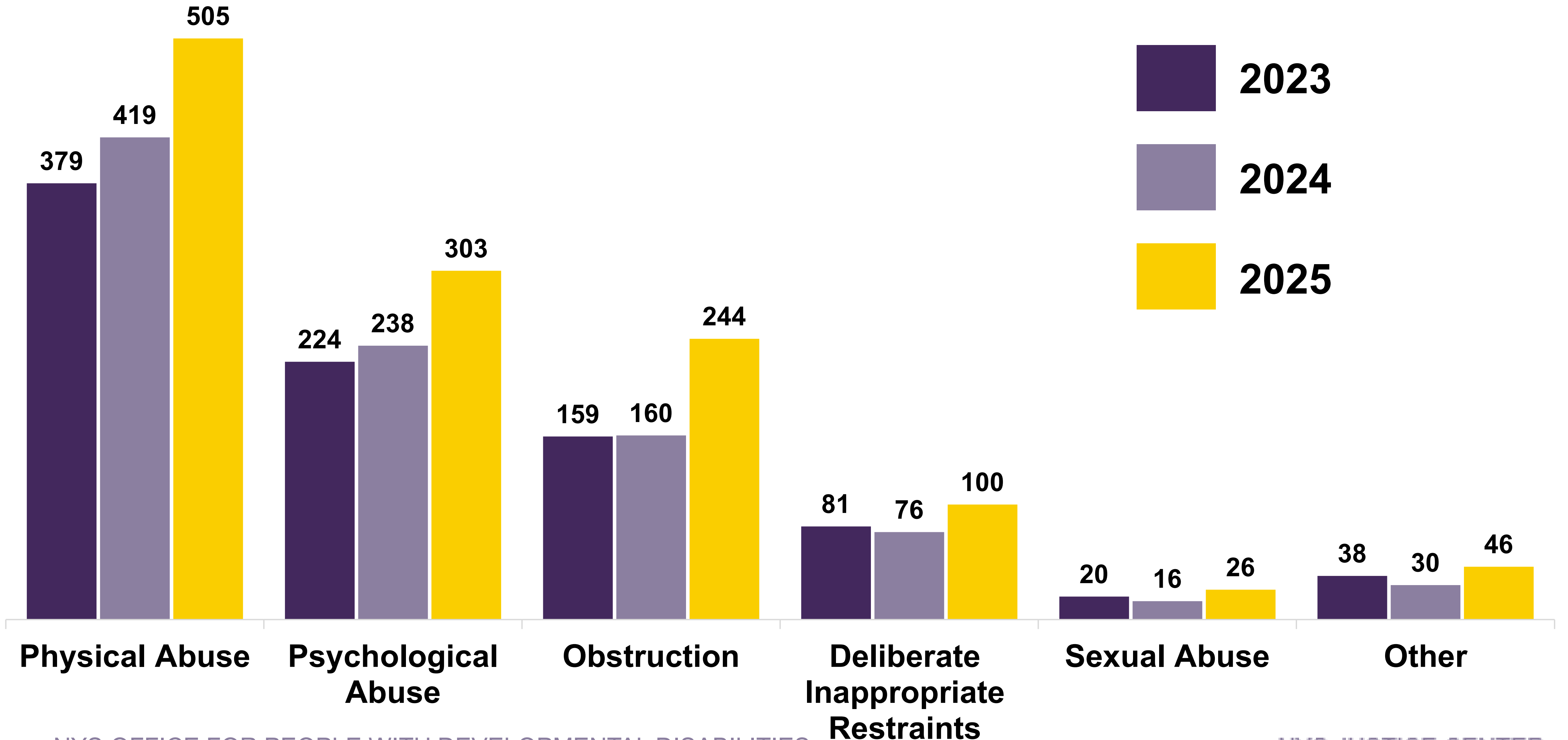
of abuse and neglect cases were substantiated



OPWDD MOST COMMON NEGLECT FINDINGS



OPWDD SUBSTANTIATED OFFENSES: ABUSE



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TRENDS IN CORRECTIVE ACTION PLAN (CAP) AUDITS

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WHAT DOES PQI AUDIT?

- ✓ Systemic A/N (Category 4)
- ✓ Mortality-involved A/N cases
- ✓ Notable Cases
- ✓ Referrals from internal business units

AUDIT FINDINGS

Implemented

- Action sufficiently addressed issue of concern and was fully implemented

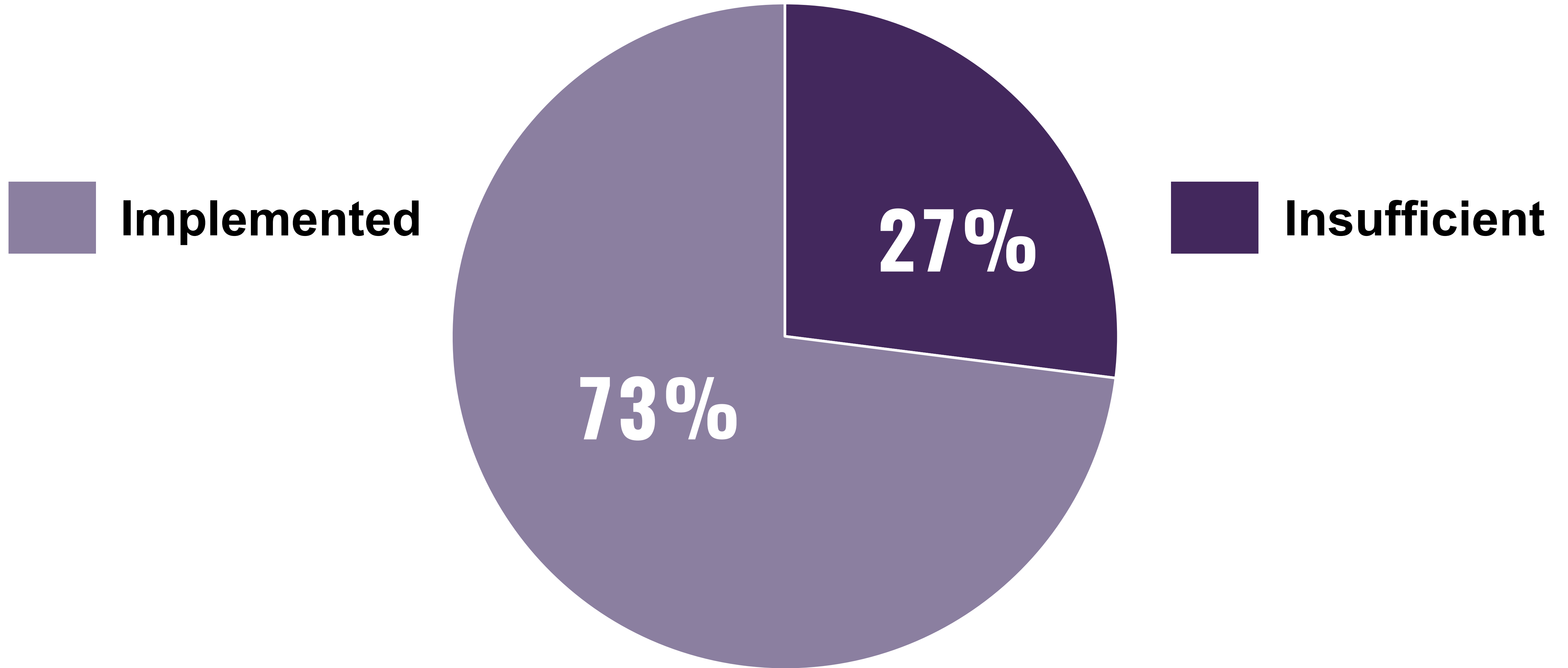
Insufficient

- Did not sufficiently address concern
- Not timely
- Not fully implemented

Other

- Miscellaneous
- Example: Subject staff resigned before corrective action occurred

CAP AUDIT FINDINGS: 2025 OPWDD



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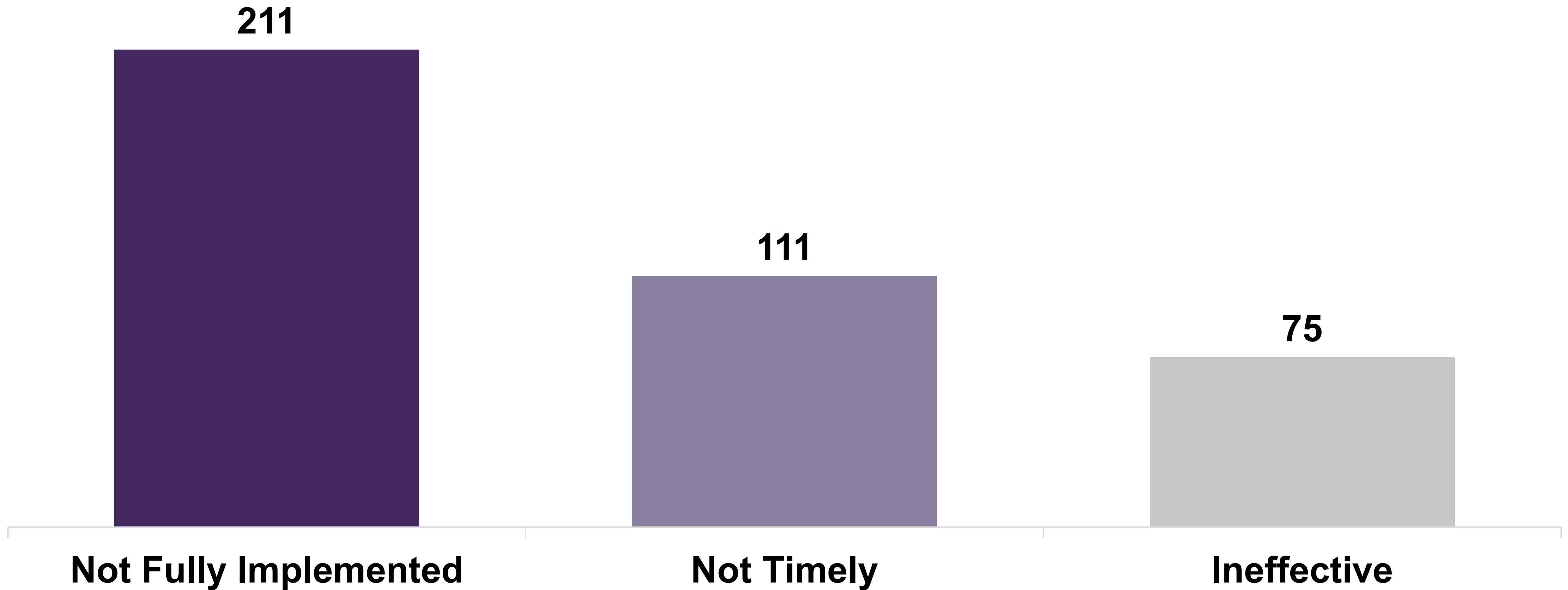
2025 AUDIT INSUFFICIENT FINDINGS



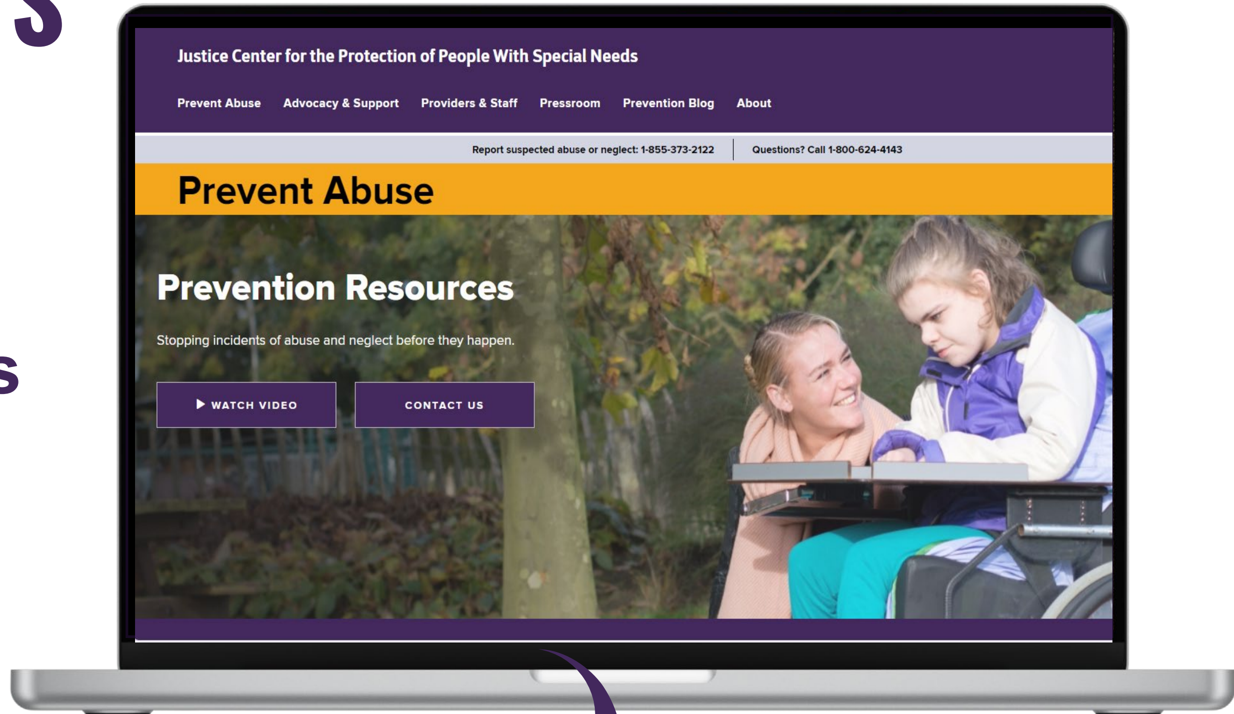
INSUFFICIENT FINDINGS BREAKDOWN

The most common insufficient findings include:

- Training-related
  - Not all staff trained
  - Not timely
  - Training did not address the concern/issue
- Immediate safeguards were not timely
- Concerns in the investigative summary report (ISR) were not addressed

PREVENTION MATERIALS

- ✓ Code of Conduct
- ✓ Spotlight on Prevention Toolkits
- ✓ Could This Happen in Your Program? Podcast
- ✓ Best Practices for Abuse-Free Environments



Scan to access!

PREVENTION TOOLKITS

Body Checks	Dangers of Being Left Unattended in Vehicles	Dangers of Caregiver Fatigue	Dangers of Intestinal Obstructions
Maintaining Professional Boundaries	Medical Emergencies	Reducing the Use of Restraints	Securing Wheelchairs in Vehicles
Best Practices for Effective Medical Care	Best Practices for Abuse Free Environments	Best Practices for Choking Prevention	Corrective Action Plan Guidance
Could This Happen In Your Program: Complete Toolkit	Professional Boundaries for Peer Support Workers	Best Practices for Community Outings	Best Practices for Providing Supervision

TOOLKITS INCLUDE

- ✓ Explanation of the issue and its importance
- ✓ Best practices for administration, staff, and others depending on the subject
- ✓ Example forms for providers to utilize
- ✓ Training recommendations
- ✓ “Could This Happen In Your Program” Case Scenarios

TOOLKIT: SUPERVISION BEST PRACTICES

Spotlight on Prevention

BEST PRACTICES FOR PROVIDING SUPERVISON

This toolkit was created to provide agencies with resources to help develop and implement consistent and understandable supervision policies and practices to help prevent lapses of supervision that result in harm or likelihood of harm to people receiving services.

The forms and tools included along with best practices include:

- Supervision and Safeguard Quick Reference Form
- Shift Assignment Sheet Template
- Care Plan Review Form
- Transfer of Supervision Form Template
- Documentation of Periodic Monitoring Form
- Administrative Observation Form Template

TOOLKIT: EFFECTIVE MEDICAL CARE

This toolkit includes best practices for Care plans, Agency policies, Resources, Education, and Staff (CARES), and special topics such as:

- Safe Patient Handling
- New Program Admissions
- Discharges from Medical Facilities
- End of Life Care – Surrogate Decision-Making Committee (SDMC)

TOOLKIT: MEDICAL EMERGENCIES

This toolkit provides guidance on recognizing medical emergencies, preparing staff and program environments, as well as the following documents:

- Mock Emergency Drill Form
- CALM Chart
- Sample Pain Chart
- Medical Hierarchy Chart
- Quick Reference Guide

TOOLKIT: CHOKING PREVENTION

This toolkit outlines the best practices for settings, training, observations, and prevention strategies as well as the following documents:

- Dining Fact Sheet
- Meal Observation Form
- Mock Emergency Drill Form

TOOLKIT: PROFESSIONAL BOUNDARIES

A self-paced, interactive training is available on the Justice Center website. Registration is also available for live, virtual trainings! This toolkit includes:

- Protecting Professional Boundaries Fact Sheet for People Receiving Services, Staff, and Provider Agencies
- Guidance for developing a professional boundary policy
- Guidelines for a Social Media Policy and Staff Education
- Consent Poster

TOOLKIT: TRAINING AGENCY STAFF

Soon to be released, the **Best Practices for Training Agency Staff** toolkit, which will include:

- New Staff Training Checklist
- New Staff Shadowing Tracker
- Training Sign-In Sheet
- Template and Sample!
- Training Attestation Example
- Review Quiz
- Mock Emergency Drill Form

OPWDD – DIVISION OF QUALITY IMPROVEMENT

INCIDENT TRENDS, RESOURCES, AND RESPONSE STRATEGIES

AND

BUREAU OF PROGRAM CERTIFICATION (BPC) SURVEY TRENDS

Justice Center for the Protection of People with Special Needs

Office for People With Developmental Disabilities

Presentation Overview

This presentation will cover:

- Significant Incident (SI) and Serious Notable Occurrence (SNO) Trends
- OPWDD Trend Informed Resources
- Strategies for Utilizing OPWDD Resources
- BPC Survey Trends

SIGNIFICANT INCIDENT AND SERIOUS NOTABLE OCCURRENCE TRENDS

Justice Center for the Protection of People with Special Needs

Office for People With Developmental Disabilities

Definition of a Significant Incident (SI)

An incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services.

Significant Incident Classifications

- Conduct Between Persons Receiving Services
- Seclusion
- Unauthorized Use of Time Out
- Medication Error with Adverse Effect
- Inappropriate Use of Restraints
- Mistreatment
- Missing Person
- Unauthorized Absence
- Choking, with Known Risk
- Choking with No Known Risk
- Self-Abusive Behavior, with Injury
- Injury, with Hospital Admission
- Theft and Financial Exploitation
- Other Significant Incident

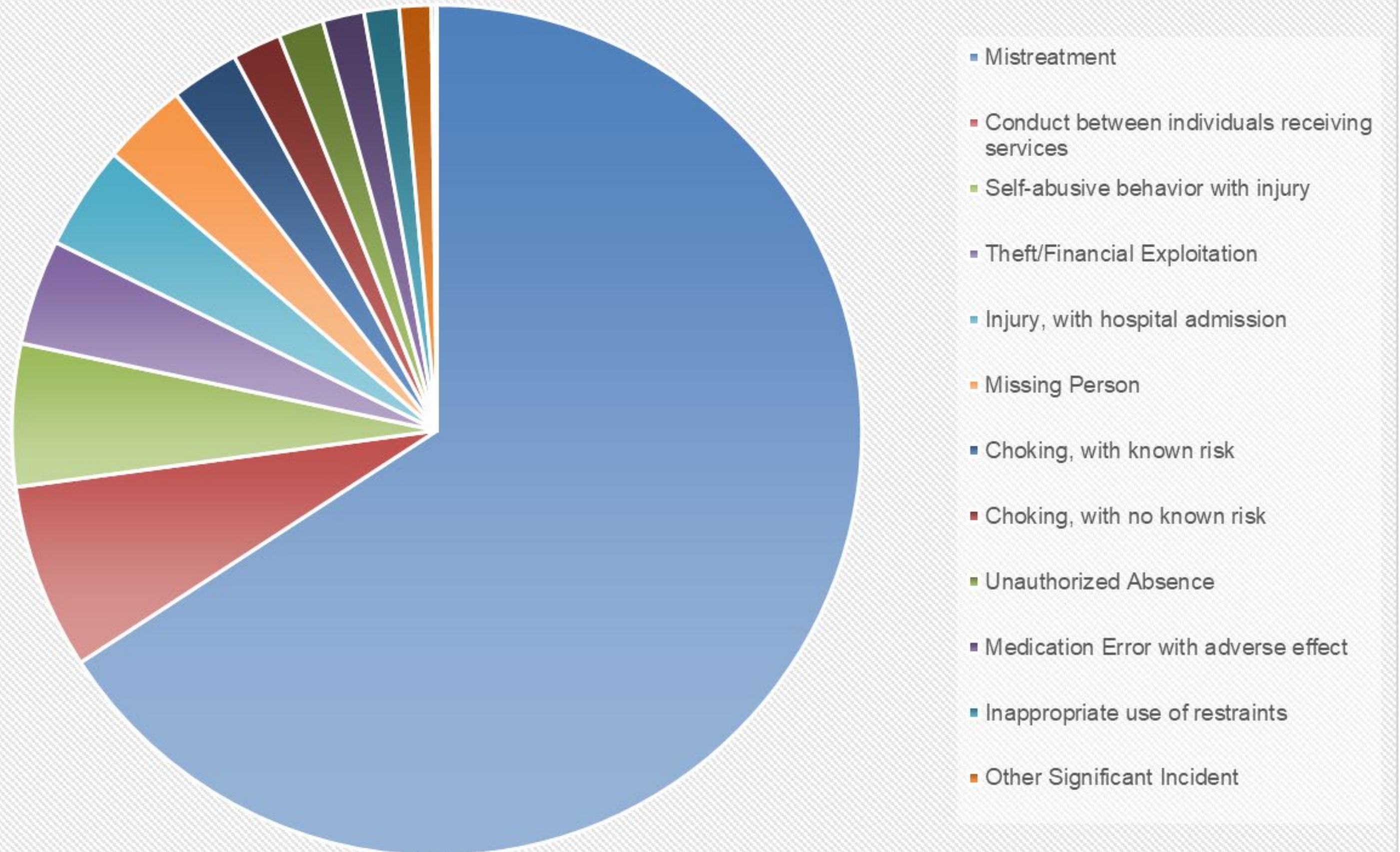
2025 Significant Incident Trends

In calendar year 2025, there were 10,660 Reportable Significant (RS) Incidents under the Justice Center's authority.

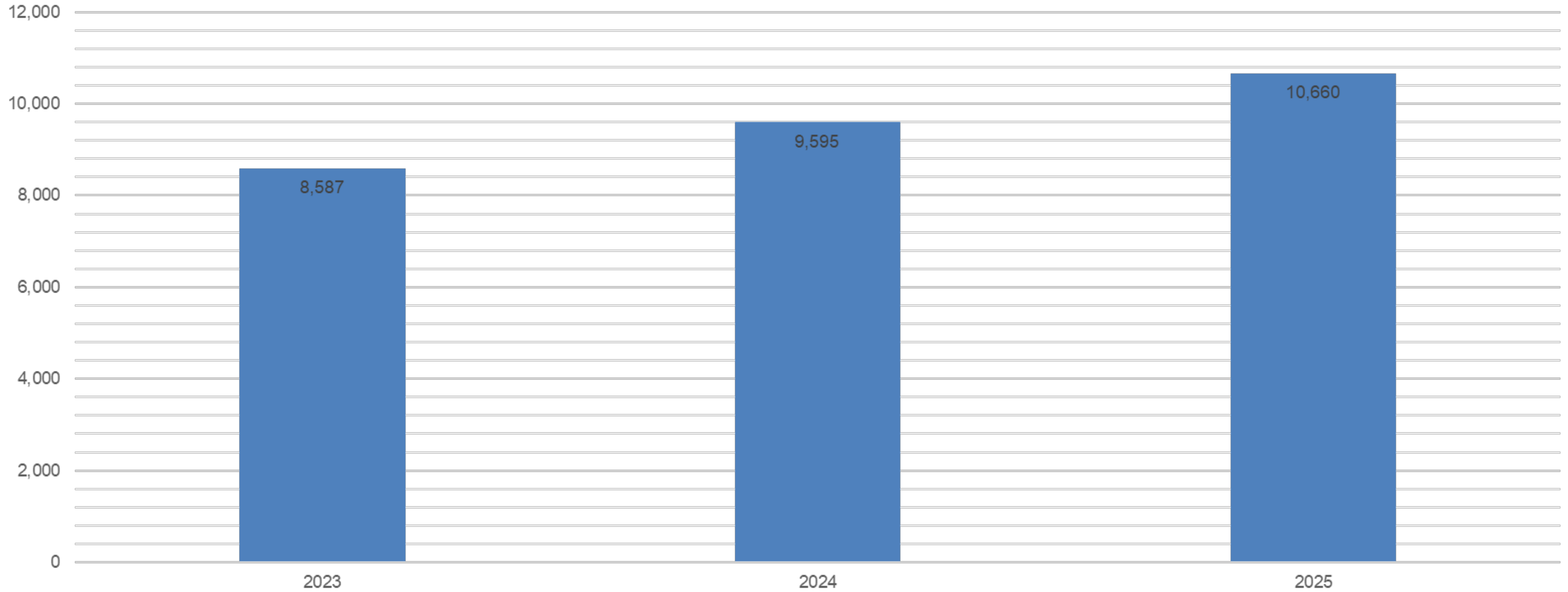
- State Operated = 2,564
- Voluntary Agencies = 8,096

The most common RS reported in 2025 was Mistreatment, accounting for approximately 66% of all RS reported.

Conduct Between Individuals Receiving Services was the next highest category, at 7.1%.



Significant Incidents – Three Year Comparison

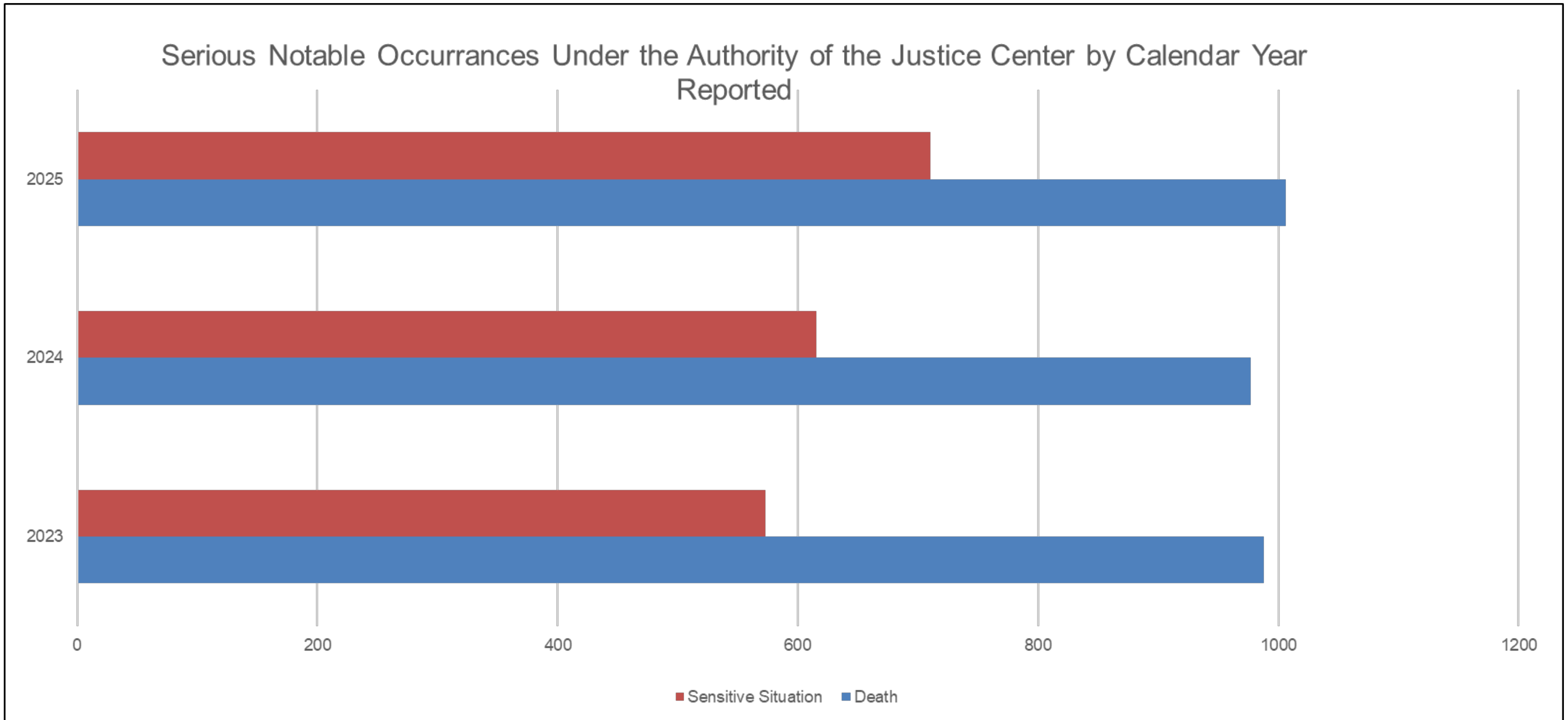


Serious Notable Occurrence Category and Classifications

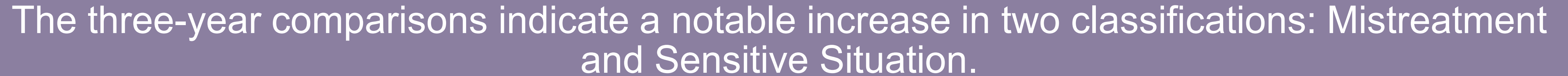
A Serious Notable Occurrence (SNO) is a category of event that includes two classifications:

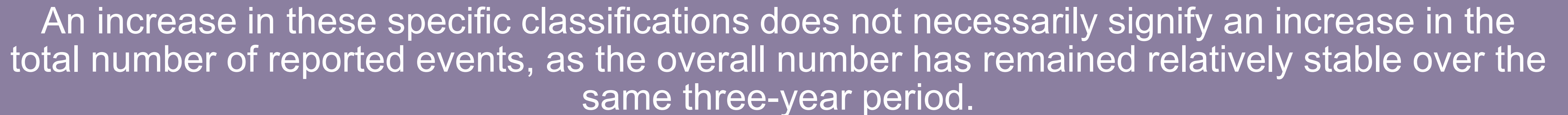
- Sensitive Situation
- Death

Serious Notable Occurrences – Three Year Comparison



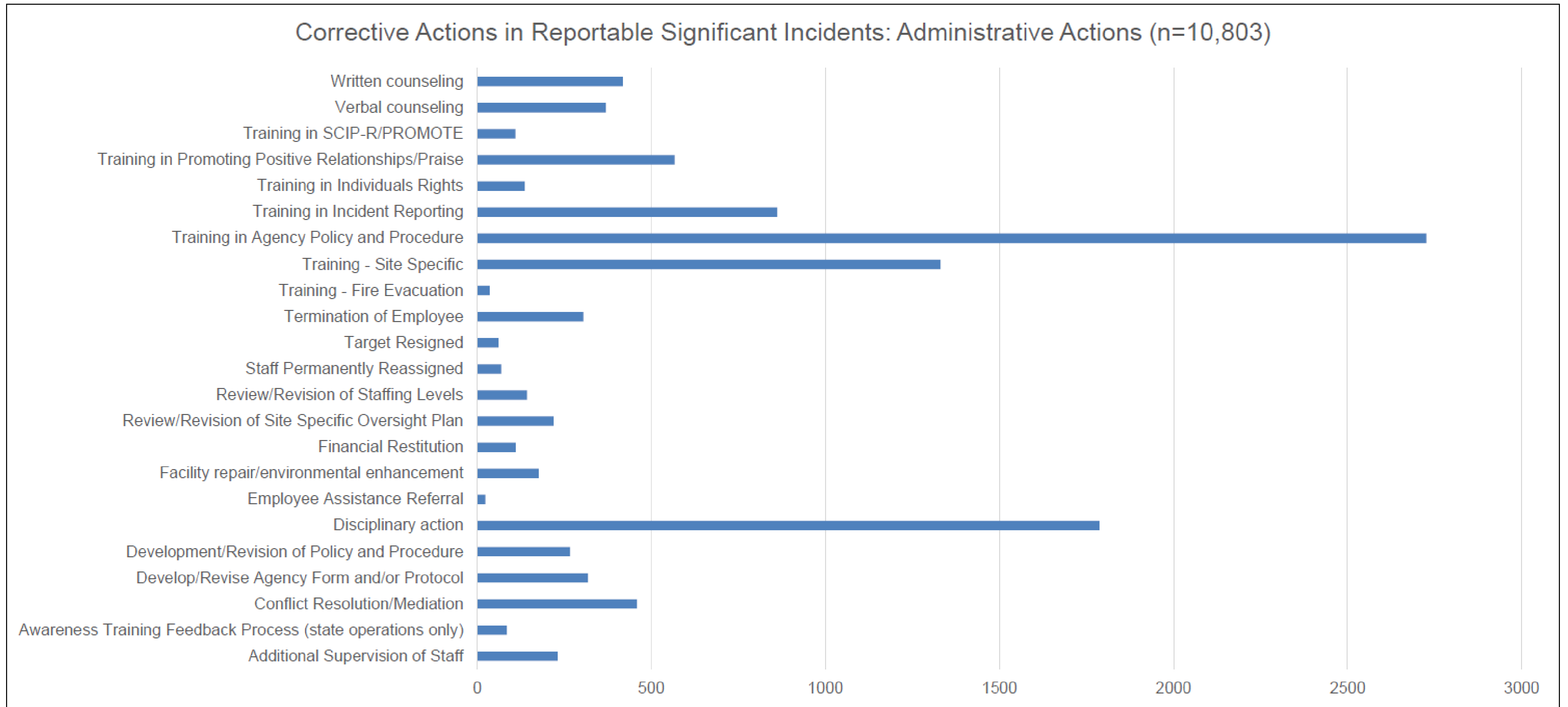
Significant Incident and Serious Notable Occurrence Data – What Does It Mean?



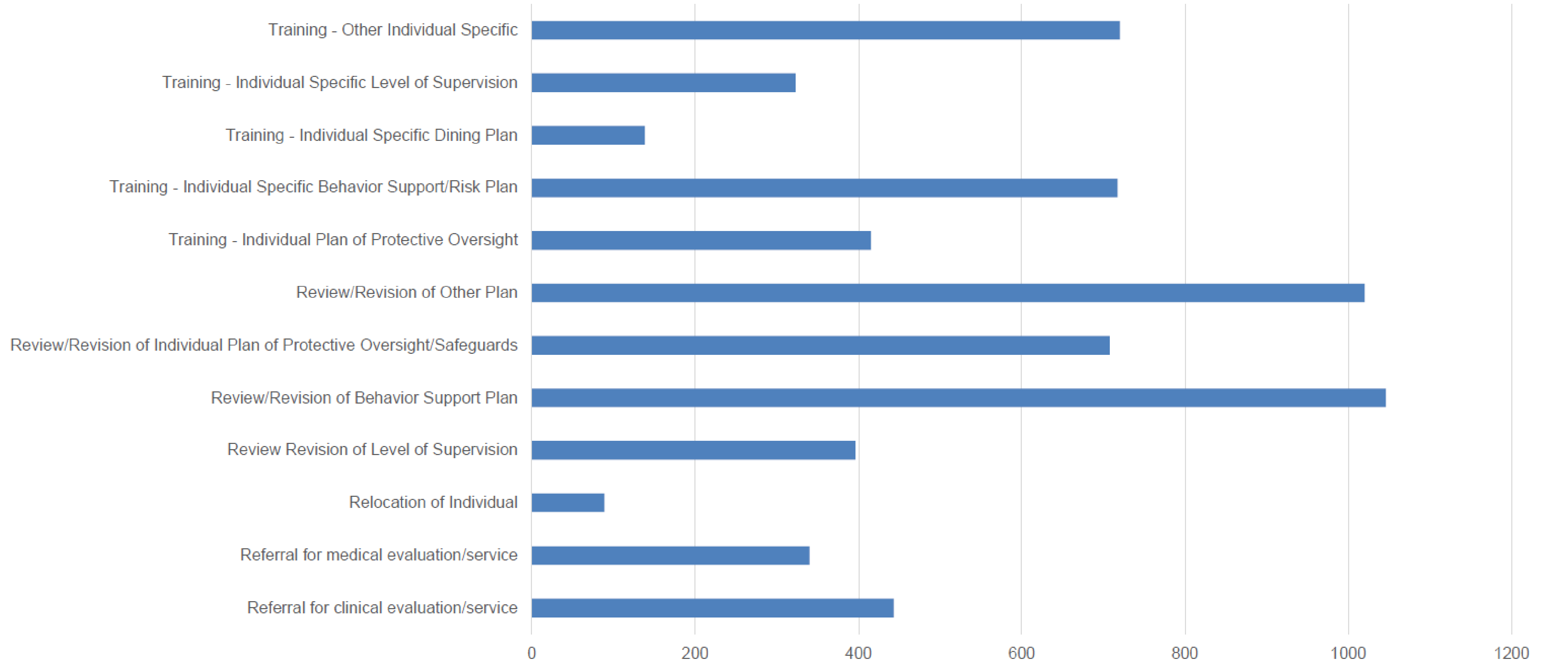


This suggests that through the Justice Center's Three Business Day Review Process, events are being classified more accurately. This leads to a shift in the number of incidents within particular classifications, rather than an increase in the total number of reported events.

Corrective Action Trends – Administrative Actions



Corrective Action Trends – Individual Specific Actions



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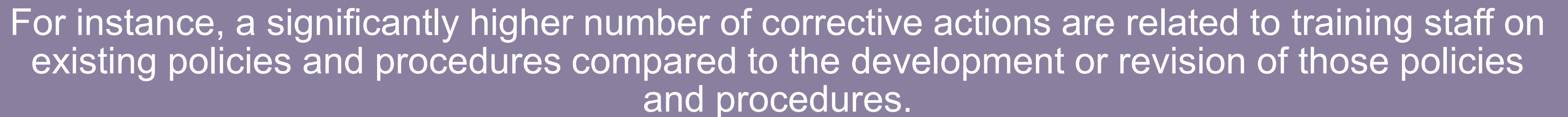
Corrective Action Trends – Understanding the Data



This trend suggests that while most agencies excel at developing and revising policies and procedures, they encounter challenges in effectively educating staff on these policies to ensure consistent implementation.

Corrective Action Trends at the Agency Level

- By regulation, an Incident Review Committee (IRC) is mandated to identify trends within reportable incidents and notable occurrences.
- This analysis should encompass a comprehensive review of various factors, including incident type, the individual involved, the location, employee involvement, time, date, and specific circumstances.
- Adhering to these requirements represents the minimum expectation for agencies.

Corrective Action Trends at the Agency Level, Continued

- If your agency is not currently performing this type of analysis, it is strongly recommended that you begin collecting data on the corrective actions being implemented.
- By doing so, your IRC will be better equipped to identify trends that reveal the underlying causes of incidents and notable occurrences within your programs and to develop strategies to prevent reoccurrence of similar incidents.

Positive Data Related to Waiver Measures

Waiver Measures	Percent Met 2024/2025	Percent Met 2023/2024
The number and percent of investigations that were completed within the appropriate timeframes. (Investigation completed in 30 days).	90.7%	87.2%
The number and percent of physical and sexual abuse incidents that were appropriately reported to law enforcement.	100.0%	100%
The number and percent of investigations that were initiated within the appropriate timeframes. (Started immediately or within 24 hours).	94.6%	94.1%
The number and percent of incidents reported within the required timeframes.	95.6%	94.0%
The number and percent of investigations where there was evidence that the necessary protections of affected individuals were implemented when appropriate.	100.0%	100%

OPWDD TREND-INFORMED RESOURCES

Justice Center for the Protection of People with Special Needs

Office for People With Developmental Disabilities

Response to Identified Trends

Many incident-related resources developed by OPWDD are created in response to identified trends.

These resources aim to raise awareness of specific issues, enabling provider agencies to proactively implement measures that minimize the likelihood of such occurrences.

Occasionally, identified trends prompt changes in regulations or the issuance of Administrative Memoranda.

Sources of Information

Incident reporting data is just one of several sources used to develop resources. Other sources include:

Complaints	Feedback from advocacy groups	Data from surveys conducted by the Bureau of Program Certification	Information received from the Centers for Medicare and Medicaid Services	Information received from the NYS Justice Center

All these sources, and others, guide the resource development process.

Types of Resources

Emails to your agency's dedicated incident management mailbox.

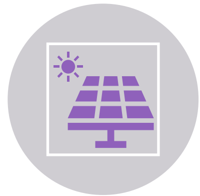
Quarterly DQI (Division of Quality Improvement) Provider Trainings

OPWDD Health and Safety Alerts

Administrative Memoranda

Updates to the Commentary of the Part 624 and Part 625 Handbook

Regulatory Changes



DQI Successful Strategies Panels

Outreach to Provider Associations

Recent Examples

A parent advocacy group reported to OPWDD that their child's Care Manager was not being notified of reported incidents. In response to this feedback, the Incident Management Unit sent an email reminder to agency's dedicated incident management mailboxes and presented on the topic at a quarterly Care Manager training.

Through the review of incident contributing factors, it was determined that failure to adhere to supervision levels and maintain professional boundaries were leading causes of many incidents. In response to supervision concerns, OPWDD issued an administrative memorandum standardizing supervision levels. Training tools are also being developed to address professional boundary concerns.

Recent Examples, Continued

OPWDD received information from the NYS Justice Center's Office of Incident Management and direct complaints from employees regarding breaches of confidentiality (i.e., confidentiality of the reporter, target(s), or witness(es) of an incident). In response, OPWDD incorporated this topic into its quarterly provider training.

OPWDD learned from parent advocacy groups that their children, who communicated in non-traditional ways, were being excluded from investigations (i.e., not interviewed). In response, OPWDD presented on this topic at a quarterly provider training.

Understanding the Importance

Understanding the rationale behind these resources underscores their significance as tools for initiating positive change at the agency level.

In the upcoming and final section, we will discuss how to effectively utilize these resources to foster more positive outcomes for the individuals you support.

STRATEGIES FOR UTILIZING OPWDD RESOURCES

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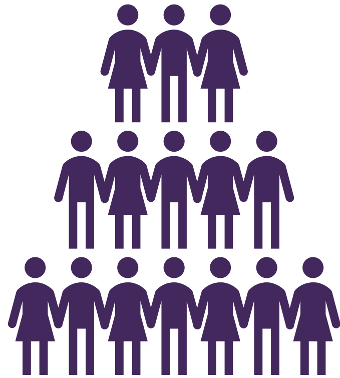
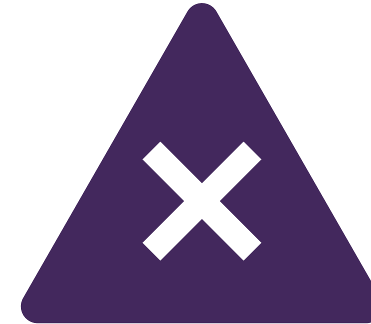
Moving Beyond Simple Dissemination



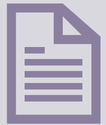
Resources shared by OPWDD should be disseminated throughout your agency as appropriate.



If your agency's engagement stops at information dissemination, it is highly recommended that you consider taking further action.

Suggested Actions

Form a Response Committee: Establish a dedicated committee to respond to incident management resources developed by OPWDD. This could be a subcommittee of your agency's IRC.



Review Agency Policies and Procedures: Ensure current policies align with best practices and resource recommendations.

Review Agency Training Curriculum: Integrate relevant information and skills into staff training.

Suggested Actions, Continued

Develop Methods to Assess Staff Competence: Evaluate staff understanding and application of protocols.

Establish a Mechanism for Measuring Progress and Success: Implement systems to track the effectiveness of implemented changes.

Nationwide Assessment of Incident Management

In October 2023, the Centers for Medicare and Medicaid Services (CMS) released the findings of a nationwide incident management assessment.

The assessment indicated that most states are performing well in reporting and responding to individual incidents, as well as in collecting data to identify trends.

However, the assessment highlighted that many states struggle with effectively responding to identified trends in a manner that reduces the occurrence of incidents.

Going Beyond Agency Trends

Incident Review Committees (IRCs) are mandated by regulation to identify and respond to trends. While this is a crucial responsibility, its scope is limited to events occurring within the agency. *IRC Tip: Make sure you are utilizing the many reports available to you in the Incident Report and Management Application (IRMA).*

By enhancing your agency's response to resources developed by OPWDD (i.e., going beyond simple dissemination), you will be actively addressing trends identified by OPWDD, thereby supplementing the important work your agency's IRC performs in response to agency-level trends.

KEY TAKEAWAYS

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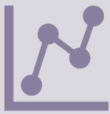
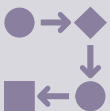
Key Takeaways



Data-Driven Insights: Recording data on corrective actions at the agency level facilitates the identification of trends, which can then be used to address the systemic root causes of incidents and notable occurrences.

Trend-Informed Resources: OPWDD resources, available in various formats, are developed in response to identified trends.



Beyond Dissemination: Engaging with OPWDD resources should extend beyond simply distributing information. A formal review process, potentially leading to systemic change, can reduce the likelihood of the issues that prompted the resource's development from occurring within your agency.

BUREAU OF PROGRAM CERTIFICATION SURVEY TRENDS

Justice Center for the Protection of People with Special Needs

Office for People With Developmental Disabilities

BPC Review Types

- Site Based Protocol Reviews
  - Full Review
  - Truncated Review
  - Remote Review
- Agency Review

Incident Standards Reviewed

Agency Review (Topic 10)

agency_protocol_manual_provider_copy_2-2019.pdf

Site Based Protocol (Section 6)

srp-manual-2025-final_0.pdf

Site Based Protocol

Referenc e #	Standard Text	SOD
6-13	Investigations of Reportable Incidents and Notable Occurrences are thorough and documented.	74
6-14	Measures identified to prevent future similar events were developed and implemented. *(1 Immediate Jeopardy SOD issued)*	72
6-9	Events that meet the definition of reportable incident or notable occurrence have been reported.	62
6-15	Corrective Actions reported to OPWDD and the Justice Center in response to Reportable Incidents of Abuse and/or Neglect were implemented.	22
6-12	Measures to protect individuals receiving services from harm and abuse, were implemented immediately	11

Agency Review (Section 10)

Reference #	Standard Text	SOD
7-3	The Incident or occurrence is closed in IRMA within acceptable time frames.	15
3-1	The agency's IRC membership meets regulatory and agency requirements.	9
1-1	The agency has procedures to ensure that individuals are offered written information regarding incident reporting policies and procedures when beginning services and annually thereafter.	7
7-4	The agency completed timely submission of an acceptable Reportable Abuse/Neglect investigation record via the WSIR.	11
7-1	The Reportable Incident or Serious Notable Occurrence is	3

Top Deficiencies

The top five most deficient sections for non-ICF **Site Reviews** from 10/1/2023 to 9/30/2024 included:

1. Health Support & Medications
2. Fire Safety (required by OFPC or DQI)
3. Site & Safety (general operation, cleanliness, maintenance of the home)
4. Delivery of Safeguards, Services, Supports
5. Rights Protections

The top five most deficient sections for **Agency Reviews** from 10/1/2023 to 9/30/2024 included:

1. Incident Management Performance Measures (Timely Investigations)
2. Incident Review Committee (IRC) - General Requirements
3. Personal Allowance Policy/Procedure
4. Staff Evaluation and Competency
5. Initial Training

Successful Strategies

- Policies and Procedures
- Test your systems
- Observe, interview, review
- Connect with staff
- Ask “Why”
- Assessment/Predictive Compliance
- Engage in the Quality Measures
- Make the connections to people and their desired outcomes

THANK YOU!

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QUESTIONS?

For questions related to OPWDD incident management, please email:
Incident.management@opwdd.ny.gov

For questions related to OPWDD surveys and certifications, please email:
quality@opwdd.ny.gov

For questions about Justice Center resources or scheduling a presentation, please email:
prevention@justicecenter.ny.gov

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