FY 2025-2026

Annual Mortality Report

for

Home and Community Based Services (HCBS)

Developmental Disability (DD) Waivers

State of Nebraska

Department of Health and Human Services (DHHS)

Division of Disability and Aging (DDA)

Reporting Period: Fiscal Year 2025-2026

Waiver Programs Covered: Family Supports Waiver (FSW), Developmental Disabilities Adult Day (DDAD) Waiver, and Comprehensive Developmental Disabilities (CDD) Waiver

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SECTION 1: EXECUTIVE SUMMARY & OVERVIEW

1.1 Purpose and Scope

This Mortality Report summarizes and analyzes all recorded deaths among individuals enrolled in Nebraska's Home and Community-Based Services (HCBS) Developmental Disability (DD) waivers during the fiscal reporting period of July 1, 2025 through June 30, 2026. The scope of this evaluation encompasses Nebraska's three distinct specialized programs: the Family Supports Waiver (FSW), the Developmental Disabilities Adult Day (DDAD) Waiver, and the Comprehensive Developmental Disabilities (CDD) Waiver.

This report serves as a core administrative mechanism for state-level quality assurance, systemic risk oversight, and federal Centers for Medicare and Medicaid Services (CMS) compliance. By conducting a data-driven analysis of mortality patterns, the Department of Health and Human Services, Division of Disability and Aging (DHHS-DDA) aims to identify preventable risk factors, evaluate the quality of community-based care, and implement targeted systemic quality improvement interventions across Nebraska's provider network.

1.2 Key Findings

During the FY 2025–2026 reporting period, the combined unduplicated enrollment across Nebraska's Developmental Disability (DD) waiver programs reached **6,792** participants, with a total of **81** recorded mortalities.

- **Crude Mortality Rate:** The DD waiver cohort demonstrated a crude mortality rate of 11.92 deaths per 1,000 participants, with a system-wide average age at the time of death of 55.00 years.
- **Leading Cause:** Infection-related conditions served as the primary clinical driver of mortality, accounting for 41.98% of all deaths (34 mortalities), driven significantly by respiratory tract infections and sepsis.
- **Leading Trends:** Chronic, progressive systemic conditions remained highly prevalent, with cardiovascular disease tracking as the second leading cause of death at 14.81% (12 mortalities).

SECTION 2: METHODOLOGY & DATA COLLECTION

2.1 Data Sources and Collection Platforms

Mortality data analyzed in this report is compiled directly from aggregated statewide health registries, state Medicaid administrative data, and provider-submitted incident tracking systems. The primary electronic platform for capturing active community-based mortality data is Therap, where Nebraska service providers are mandated to submit a General Event Report (GER) within 24 hours of a participant's passing. These initial electronic reports are cross-referenced quarterly with the Nebraska Department of Health and Human Services (DHHS) Office of Vital Statistics death certificate database. This reconciliation process resolves data discrepancies, verifies official ICD-10 primary causes of death, and captures occurrences where a participant may have passed out-of-state or outside services.

The secondary platform utilizing this data is the Quality Improvement Data System (QIDS). The Division's Quality Improvement Organization (QIO)-like partner, Liberty Healthcare, utilizes QIDS to document formal reviews of all mortalities, all high-notification level GERs, and a mandatory 10% stratified sample of medium-notification level GERs across the state.

2.2 Data Limitations and Reporting Scope

While the data in this report provides a comprehensive overview of system-wide trends, specific limitations must be factored into interpretation:

- **Provisional Cause of Death:** Initial provider-reported causes of death documented on Therap GERs are frequently provisional and based on immediate medical observations, such as "cardiac arrest." These are updated when official, ICD-10-coded death certificates become available from the state registry, which can introduce localized reporting lags.
- **Enrollment Fluidity:** Data calculations rely strictly on "unduplicated enrollment," which means any individual actively enrolled in a Nebraska DD waiver for at least one day during the fiscal year. This dynamic denominator may cause slight statistical variances when compared to static, single-day point-in-time enrollment snapshots.

2.3 Components of the Mortality Review Process

To comply with CMS quality assurance benchmarks, all mortality reports trigger a multi-tiered administrative and clinical review conducted by our QIO partner designed to maximize health, safety, and system accountability:

- **Initial Clinical Triage**: Upon notification of a death, a mortality reviewer completes a standardized screening. Expected deaths without quality-of-care concerns are documented and closed. Deaths involving potential abuse, neglect, exploitation,

quality-of-care concerns, or risks to others trigger the Others-at-Risk protocol and notification to DHHS-DDA.

- **Expedited In-Depth Review:** Deaths that are sudden, unexpected, involve alleged abuse, neglect, exploitation, or indicate possible lapses in medical care are escalated for comprehensive review. The reviewer analyzes records, develops a timeline, and evaluates preventability, systemic issues, and provider performance, with completion targeted within **45 calendar days** of receiving records.
- **Multi-Level Clinical and Committee Review:** Flagged or complex cases advance through progressive tiers of multidisciplinary oversight:
    - **Second Level Physician Review:** A QIO Physician reviews the file to evaluate complex medical causes of death and the clinical appropriateness of provider care.
    - **Mortality Review Team (MRT):** A clinical and healthcare experts team meets to evaluate unexpected deaths, issuing localized provider-specific recommendations or escalating cases further.
    - **Mortality Review Committee (MRC):** A quarterly panel composed of internal and external stakeholders—including medical experts, advocates, pharmacists, and data analysts—evaluates escalated cases to identify systemic issues and transmits strategic policy recommendations to the DDA Quality Improvement Committee.
- **Corrective Action and Case Closure:** Based on the multi-tiered findings, formal recommendation letters are issued to DD waiver providers, Service Coordinators, or Targeted Case Managers. The QIO and DDA Quality Unit deploy targeted technical assistance to ensure timely remediation and prevention of recurrence. A case is officially closed only when a formal recommendation or closure letter is transmitted to all responsible parties.

SECTION 3: DEMOGRAPHIC & BASELINE MORTALITY TRENDS

3.1 Analysis of Total Program Sample

The data analyzed in this section establishes a baseline by comparing Nebraska's total unduplicated participant enrollment against documented mortalities across the distinct HCBS waivers. Using unduplicated population totals establishes a precise, comprehensive denominator to calculate exact crude mortality rates.

3.2 Demographics Analysis

The average age of death for Nebraska waiver participants during this reporting period was **55 years**. Analysis by biological gender demonstrates a significant male pre-eminence, with males accounting for **67.90%** (55 deaths) and females accounting for **32.10%** (26 deaths) of total mortalities.

3.3 Waiver Enrollment and Crude Mortality Overview

Among Nebraska's DD waivers, the Comprehensive Developmental Disability (CDD) Waiver represents the largest cohort, accounting for all 81 documented mortalities. This heavy concentration is clinically and administratively expected; the CDD Waiver hosts the largest number of assigned participants and supports individuals with the highest physical, behavioral, and medical acuity profiles requiring 24-hour staffed services.

Table 1: Macro Mortality Metrics by Nebraska DD Waiver Program

HCBS Waiver Program	Total Enrolled Unduplicated Population	Total Documented Mortalities (N)	Calculated Crude Mortality Rate (per 1,000)	Average Age at Death
Comprehensive (CDD)	*5,043*	81	*16.06*	*55*
Adult Day (DDAD)	*819*	0	N/A	N/A
Family Supports (FSW)	*930*	0	N/A	N/A
Combined Waiver Total	**6,792**	**81**	**11.92**	**55 Years**

Table 2: Combined Mortality Analysis by Age Cohort

Age Range	Active Waiver Enrollment	Enrollment Share (%)	Deceased Participants (Count)	Mortality Share (%)
0–19	1,029	15.15%	1	1.23%
20–29	1,762	25.94%	10	12.35%
30–39	1,446	21.29%	10	12.35%
40–49	1,126	16.58%	9	11.11%
50–59	683	10.06%	15	18.52%
60–69	485	7.14%	16	19.75%
70–79	215	3.17%	13	16.05%
80 and Above	46	0.68%	7	8.64%
Total	**6,792**	**100.00%**	**81**	**100.00%**

Table 3: Mortality Distribution by Biological Gender

Biological Gender	Active Waiver Enrollment	Enrollment Share (%)	Deceased Participants (Count)	Mortality Share (%)
Male	4,250	62.57%	55	67.90%
Female	2,542	37.43%	26	32.10%
Total	**6,792**	**100.00%**	**81**	**100.00%**

Table 4: Mortality Distribution by Racial Classification

Racial Classification	Deceased Count	Deceased Share (%)	Overall Waiver Enrollment Baseline (%)
White	73	90.12%	81.87%
Black / African American	4	4.94%	7.19%
Multi-Racial (Black and White)	1	1.23%	1.03%
Unknown	1	1.23%	3.96%
Other	1	1.23%	2.70%
Declined to State	1	1.23%	1.68%
Asian	0	0.00%	1.58%
Total	**81**	**100.00%**	**100.00%**

3.4 Geographic and Community Size Analysis

An evaluation of the geographic distribution of waiver participants highlights a statistically significant variance in mortality rates within rural communities. While system-wide data indicates that mortality rates in metropolitan and non-metropolitan areas closely align with overall enrollment baselines, participants residing in rural localities experienced a disproportionately higher rate of mortality relative to their total representation in the waiver programs.

- **Rural Communities:** Participants residing in rural cities and towns constitute 25.87% of the total waiver enrollment, yet they accounted for 30.86% of all recorded mortalities (25 deaths). This indicates an elevated mortality rate relative to enrollment size, highlighting a potential area for targeted healthcare access and provider oversight tracking.
- **Metropolitan Areas:** Urban centers demonstrated a highly stable baseline. Metropolitan residents represent 54.02% of total waiver participants and accounted for a near-identical 53.09% of mortalities (43 deaths).
- **Non-Metropolitan Areas:** Similarly, non-metropolitan regions (semi-urban) showed no elevation in risk, comprising 20.11% of the waiver population and accounting for 16.05% of mortalities (13 deaths).

The data suggests that while systemic risks remain low in metropolitan and mid-sized regions, further quality assurance monitoring is required to determine if rural mortality variances are linked to localized social determinants of health, such as emergency response times or proximity to specialized medical care.

Table 5: FY 2025–2026 Mortality Distribution by Community Typology

Community Typology	Active Enrollment (Count)	Enrollment Share (%)	Recorded Mortalities (Count)	Mortality Share (%)
Metropolitan	3,669	54.02%	43	53.09%
Non-Metropolitan	1,366	20.11%	13	16.05%
Rural	1,757	25.87%	25	30.86%
Total	**6,792**	**100.00%**	**81**	**100.00%**

3.5 Mortality Distribution by Location of Death

An evaluation of the physical location where mortalities occurred indicates a high concentration within specialized medical facilities and 24-hour agency-staffed environments. Hospital-Inpatient units and Agency-Operated Homes accounted for the largest shares of mortality in FY 2025–2026, representing 32.1% and 30.9% of all recorded deaths, respectively.

This concentration does not inherently indicate systemic deficiencies in provider care. Instead, it reflects clinical triage realities and demographic distribution: individuals with complex medical conditions, profound intellectual disabilities, and acute physical frailties are disproportionately supported within 24-hour staffed residential models. Furthermore, acute medical crises are appropriately managed via transfer to inpatient hospital settings for advanced life-sustaining interventions.

Notable shifts from the previous reporting period include:

- **Hospital Deaths:** Inpatient mortalities rose slightly to 34.57% (up from 28.8% in 2024), while Emergency Room deaths decreased significantly to 2.5% (down from 9.6%). This shift suggests that more individuals were successfully admitted for treatment prior to end-of-life events, rather than succumbing immediately win emergency care.
- **Home-Based Deaths:** Deaths occurring in a personal or family home decreased to 13.58% of the total, down from 20.5% in the previous year.

Table 6: Comparative Analysis of Death Locations (FY 2024 vs. FY 2025–2026)

Location of Death	FY 2025–26 Deaths (Count)	FY 2025–26 Deaths (%)	2024 Report Deaths (Count)	2024 Report Deaths (%)
Hospital - Inpatient	28	34.57%	21	28.8%
Agency Operated Home	27	33.33%	21	28.8%
Own / Family Home	11	13.58%	15	20.5%
Nursing Facility	4	4.9%	2	2.7%
Other	6	7.41%	5	6.8%
Hospital Emergency Room	2	2.5%	7	9.6%
Day Service Facility	1	1.2%	0	0.0%
Hospice Facility	2	2.47%	1	1.4%
Assisted Living	0	0.0%	1	1.4%
Total	**81**	**100.0%**	**73**	**100.0%**

3.6 Residential Setting Analysis

An analysis of mortality data based on the participants' residential living arrangements reveals consistent trends across the state's primary supported housing models.

Participants residing in Group Home settings accounted for 38.3% of all recorded mortalities during the FY 2025–2026 reporting period, with an average age at the time of death of 55 years. Similarly, participants enrolled in Shared Living arrangements represented 40.7% of total deaths, with an average age of mortality at 59 years. The closely aligned average age of death between these two settings suggests a stabilizing baseline for life expectancy among participants in structured residential environments, regardless of the specific service delivery model (congregate vs. family-based).

Table 7: Mortality Metrics by Residential Setting

DD Residential Setting	FY 2025–26 Deaths (Count)	Percentage of Total Deaths	Average Age at Time of Death
Group Home	31	38.3%	55
Shared Living	33	40.7%	59
Personal Home / Apartment	13	16.0%	46
Nursing Facility	4	4.9%	63

SECTION 4: CAUSE OF DEATH AND CLINICAL TREND ANALYSIS

4.1 Leading Primary Causes of Death

During the FY 2025–2026 reporting period, chronic, progressive illnesses and systemic infections remained the primary clinical drivers of mortality across the DD waiver population.

- **Infection-Related Conditions:** Infections emerged as the single largest contributor to mortality, accounting for 41% of all death causes (39 mortality causes).
    - This category includes pneumonia, aspiration pneumonia, sepsis, COVID-19, and advanced urinary tract infections (UTIs).
    - This concentration aligns with national longitudinal research demonstrating that individuals with intellectual and developmental disabilities (I/DD) exhibit elevated vulnerability to respiratory and systemic pathogens due to high rates of dysphagia, mobility limitations, and compromised immune baselines.
- **Cardiovascular Disease/ Respiratory and Nervous System Disorders:** Chronic cardiovascular and respiratory system disorders represented the second highest clinical category, accounting for 19% of death causes (18 mortality causes).
    - Documented causes within this cohort primarily consisted of sudden cardiac arrest, myocardial infarction, and progressive congestive heart failure. Nervous system deaths were driven by advanced dementia, severe seizure disorders, and cerebrovascular accidents (strokes), while respiratory system disorders primarily involved chronic respiratory failure unrelated to acute pathogens.

Table 8: FY 2025–2026 Primary Causes of Death and Clinical Classifications

Diagnostic Classification	FY 2025–26 Deaths (Count)	Share of Total Deaths (%)	Clinical Scope and Included Conditions
Infections	39	41%	Aspiration pneumonia, influenza, viral pneumonia, sepsis, septicemia, urinary tract infections (UTIs), and COVID-19.
Cardiovascular/Respiratory System	18	19%	Sudden cardiac death, myocardial infarction, congestive heart failure, cardiac arrest, atherosclerosis, and complex arrhythmias. Chronic respiratory failure, progressive lung disease, and unspecified chronic respiratory conditions.
Nervous System	16	17%	Alzheimer's disease, progressive dementia, encephalopathy, Parkinson's disease, status epilepticus/seizures, and strokes.
External Causes	5	5%	Accidental falls, acute choking events, and motor vehicle accidents.
Oncology (Cancers)	5	5%	Malignancies include breast, colorectal, pancreatic, lung, lymphoma, and leukemia.
Renal System	4	4%	End-stage renal disease (ESRD) and acute kidney failure.
Gastrointestinal / Digestive	3	3%	Acute bowel obstructions, severe gastrointestinal bleeds, and hepatic failure.
Musculoskeletal	3	3%	Duchenne Muscular Dystrophy.
Blood Condition	1	1%	Blood Condition

**The total causes exceed the total number of deaths due to multiple causes of death for some participants.

4.2 Targeted Review: Sepsis and Severe Systemic Infections

Sepsis and septicemia represent critical clinical vulnerabilities within Nebraska's DD waiver population. Review by the Mortality Review Committee (MRC) indicates that systemic infection pathways are frequently secondary complications stemming from chronic skin breakdown (decubitus ulcers), recurrent UTIs in catheter-dependent participants, or unresolved respiratory infections. Because sepsis falls within the "Fatal Five Plus" risk framework, the Quality Assurance Unit tracks demographic variations to identify systemic provider gaps.

Gender Distribution in Sepsis Mortalities

An analysis of sepsis-related deaths reveals a pronounced male pre-eminence, with men accounting for 65.22% of all sepsis mortalities compared to 34.78% for women.

This variation does not indicate a gender-specific clinical risk pattern or localized provider deficiency. Rather, it closely mirrors the overall waiver enrollment baseline, which is heavily weighted toward male participants (62.57%). The data confirms that both male and female sepsis rates align within normal statistical tolerances of their total enrollment share. The Quality Assurance Unit will continue to monitor this metric to ensure no systemic gender-based variances emerge in subsequent fiscal years.

SECTION 5: GENERAL EVENT RECORD (GER) INCIDENT REPORT LINKAGE

5.1 Retroactive Incident Mapping and Analysis

A critical component of Nebraska DHHS-DDA's quality management framework is the retroactive analysis of critical incident reports submitted prior to a participant's death. By cross-referencing Therap General Event Records (GERs), case management notes, and electronic tracking databases, the Quality Assurance Unit maps the clinical and behavioral precedents occurring prior to mortality.

During the FY 2025–2026 reporting period, a significant majority—91.36% of deceased participants (74 out of 81 individuals)—had at least one documented critical incident prior to their death. Only 7 out of 81 deceased individuals had zero recorded GER incidents during the fiscal year.

Deceased participants demonstrated a higher baseline frequency of incident generation compared to general waiver enrollment. While the average DD waiver participant generated 2.00 GERs annually, individuals who experienced mortality averaged 3.80 GER incidents prior to death.

Table 9: System-Wide GER Incidents Frequencies

Analysis Cohort	**Average Number of GER Incidents**
All Active Waiver Participants	2.00 Incidents
Active Participants with at Least 1 Reportable Incident	4.79 Incidents
Deceased Participants Only	3.80 Incidents
Deceased Participants with Zero Documented GERs	7 of 81 (8.64%)

5.2 Observations of Precedent GER Event Categories

An evaluation of specific GER categories reveals distinct variations between the general waiver enrollment and the mortality cohort. Deceased participants experienced significantly higher shares of Unplanned Hospitalizations, Emergency Services Involvement, and Fatal Five Plus incidents. Importantly, these elevated rates do not represent causal clinical factors;

rather, they serve as sentinel markers of advanced medical frailty and acute health deterioration.

Table 10: Distribution of Precedent Therap GER Events by Analysis Cohort

Therap GER Event Category	Deceased Participants Only (%) [Count]	All Waiver Participants (%) [Count]	All Participants *Excluding* Deceased Cohort (%) [Count]
Unplanned Hospitalization	24.72% [66]	11.17% [1565]	10.90%[1499]
Medication Error	14.61%[39]	14.59%[2045]	14.59%[2006]
Emergency Services Involvement	11.99%[32]	8.18%[1147]	8.11%[1115]
Possible Abuse/Neglect/Exploitation	3.37%[9]	12.18%[1707]	12.35%[1698]
Behavioral Issue	3.00%[8]	13.31%[1865]	13.51%[1857]
Fatal Five Plus Events	2.62%[7]	1.19%[167]	1.16%[160]
Injury	2.25%[6]	5.82%[816]	5.89%[810]
Communicable Disease	1.50%[4]	1.01%[141]	1.00%[137]
Fall with Significant Injury	1.50%[4]	1.12%[157]	1.11%[153]
PRN Psychotropic Use	1.12%[3]	0.64%[90]	0.63%[87]
Fall without Significant Injury	0.75%[2]	0.83%[116]	0.83%[114]
Misconduct / Possible Criminal Activity	0.75%[2]	15.54%[2178]	15.83%[2176]
Choking / Potential Choking	0.37%[1]	0.81%[113]	0.81%[112]
Emergency Safety Intervention	0.37%[1]	5.52%[774]	5.62%[773]
Prohibited Practice	0.37%[1]	0.24%[34]	0.24%[33]
Vehicular Accident	0.37%[1]	0.73%[103]	0.74%[102]

5.3 Deep-Dive: Target Clinical and Incident Trends

1. Unplanned Hospitalizations

While approximately 11.17% of all active DD waiver participants with an incident history experienced an unplanned hospitalization, nearly 25% (24.72%) of the mortality cohort experienced a hospital event prior to death.

An evaluation of the duration between medical events shows an average of 105 days between the documented unplanned hospitalization and the subsequent date of death. This extended timeline confirms that hospitalizations were not immediate precipitating or causal factors, but rather indicators of compounding systemic frailty. Quality review revealed no systemic concerns or localized provider deficiencies within these hospital events.

Table 11: Breakdown of Unplanned Hospitalizations for Deceased Cohort

Type of Unplanned Hospitalization	Incident Count (N)	Percentage (%)
Inpatient Admission	37	56.00%
Emergency Room (Without Admission)	24	36.00%
Urgent Care Visit	5	8.00%
Total Hospital-Related Incidents	**66**	**100.00%**

2. Emergency Services Involvement

Emergency services involvement accounted for 11.99% of GERs within the deceased cohort, compared to 8.18% in the general DD waiver population. However, this data vector is skewed by localized statistical outliers. Specifically, two participants accounted for a combined total of 16 emergency incidents, representing exactly 50.00% of all emergency service events recorded for the deceased cohort. When adjusting for these high-utilization individuals, the remaining cohort tracks within normal historical baselines, revealing no systemic trends or service delivery concerns.

3. Fatal Five Plus Conditions

The "Fatal Five Plus" risk framework includes conditions identified as high-risk for the I/DD population: Aspiration/Choking, Bowel Obstruction/Constipation, Dehydration, Gastroesophageal Reflux Disease (GERD), Seizure Disorders, and Sepsis/Septicemia. Fatal Five Plus accounted for 2.62% of the deceased cohort's incident history—more than double the 1.19% rate observed across the general DD waiver population.

Similar to the emergency services metric, data is heavily influenced by a narrow participant subset. Two individuals generated 5 of the 7 documented Fatal Five Plus incidents, accounting for 71.43% of the deceased cohort's total. Quality review does not reveal any systemic trends or service delivery concerns.

4. Fall Incidents and Policy Interventions

A comparative analysis shows that 12.35% of deceased participants had a documented fall history prior to mortality, compared to a 5.17% fall rate across the broader waiver enrollment. Of the 10 deceased individuals with an associated fall history, one mortality was determined to be directly attributable to a fall-related injury (representing 1.23% of total system deaths).

To proactively mitigate system-wide fall risks, the Division recently implemented a critical policy adjustment by revising the GER Reporting Guide. The updated mandate expands provider compliance requirements: all falls, regardless of whether an injury is sustained, must now be reported via a formal GER. This expansion replaces the previous framework which restricted reporting to falls with documented injuries, allowing the Quality Assurance Unit to track early mobility decline and deploy preventative physical therapy or home-modification interventions.

Table 12: Comparative Fall Metrics and Mortality Linkages

Fall Reporting Metric	Statistical Value
Total Unique Waiver Participants Experiencing a Fall (FY 25–26)	351 Participants
Waiver-Wide Participant Fall Prevalence Rate (%)	5.17%
Deceased Participant Fall Prevalence Rate (%)	12.35%
Total Number of Deceased Participants with a Precedent Fall	10 Participants
Number of Deaths Directly Attributable to Fall Complications	1 Mortality
Fall-Related Deaths as a Percentage of Total Mortality	1.23%

5.4 Safety Assurances and Risk Mitigation Targeting

1. Low Exploitation and Abuse Correlative Trend

As detailed in the comprehensive incident crosscheck, allegations of Possible Abuse/Neglect/Exploitation (ANE) accounted for only 3.37% of incident history for deceased

participants. In stark contrast, ANE allegations represented 12.18% of incidents across the general DD waiver population. This statistical divergence indicates that deaths within Nebraska's DD waivers are heavily concentrated within purely clinical categories driven by acute or chronic medical conditions, rather than systemic protective or environmental vulnerabilities.

2. Abuse, Neglect, and Exploitation (ANE) Crosscheck

In accordance with federal CMS Quality Assurance Assurances, Nebraska maintains a zero-tolerance policy for unaddressed vulnerability or provider misconduct. Every documented mortality underwent mandatory crosscheck against active and historical state protective services databases.

For the FY 2025–2026 reporting period, the agency confirms that 100.00% of cases where an allegation of abuse, neglect, or exploitation was open or filed were successfully routed to Adult Protective Services (APS), Child Protective Services (CPS), and local law enforcement for full administrative and forensic review. Following formal administrative reviews and cross-jurisdictional investigations, there were zero substantiated or confirmed incidents of abuse, neglect, or exploitation related to any recorded mortality during this fiscal year.

SECTION 6: CONCLUSION AND CLOSING STATEMENT

6.1 Report Synthesis

The FY 2025–2026 Annual Mortality Report highlights the stabilizing, complex healthcare profiles of individuals with intellectual and developmental disabilities (I/DD) served through Nebraska's HCBS DD waivers. With a system-wide crude mortality rate of 11.92 per 1,000 participants across 6,792 unduplicated individuals, mortality remains concentrated among those with the highest clinical acuity—specifically within the CDD Waiver, which accounted for all 81 recorded deaths.

Data from the Therap and QIDS platforms show that DD waiver participants experience distinct clinical and demographic vulnerabilities. The high proportion of deaths occurring in Hospital-Inpatient settings (32.1%) and Agency-Operated Homes (30.9%) reflects appropriate triage of medically fragile individuals into higher-support environments during acute health events rather than systemic provider deficiencies.

Retroactive mapping of General Event Reports (GERs) also proved valuable as a quality management tool. Among deceased participants, 91.36% had preceding significant incidents—such as unplanned hospitalizations or emergency interventions—occurring an average of 105 days prior to death. This pattern points to progressive chronic frailty rather than unaddressed or immediate lapses in care.

6.2 Closing Quality Assurance Commitment

Nebraska DHHS, Division of Disability and Aging, remains committed to a system of care that protects the health, safety, and dignity of every participant. All mortalities underwent comprehensive administrative crosschecks, and none resulted in substantiated abuse, neglect, or exploitation findings—affirming the strength of provider practices and state oversight.

The findings reinforce a core agency philosophy: mortality review is not simply a retrospective compliance requirement but a critical tool for proactive, system-wide risk mitigation. By examining the demographic and clinical variations across waiver services, DHHS can move from broad wellness monitoring to highly targeted interventions that address the specific needs of those at greatest risk.

As we move into the next fiscal year, DHHS will continue transparent collaboration with federal partners, advocates, and provider agencies to refine oversight structures, strengthen participant safeguards, and support safe, dignified community living across Nebraska's HCBS waivers.

6.3 Final Analysis and System-Level Implications

Together, these findings demonstrate a HCBS quality management system that effectively identifies, monitors, and responds to risk across the DD waiver programs.

Findings indicate a need to strengthen provider expectations for health monitoring, reinforce timely follow-up on repeated hospital utilizations, enhance care coordination for medically fragile participants, and refine provider training related to recognizing and escalating risk. These findings will be elevated to the Mortality Review Subcommittee, Incident Management Subcommittee, and the Quality Improvement Committee (QIC) to guide the next HCBS quality improvement cycle.

At the system level, the analysis confirms that Nebraska's HCBS oversight infrastructure is functioning as intended: incidents are reported and triaged appropriately, mortality reviews reveal no systemic provider deficiencies, and administrative checks validate provider integrity. This positions the DDA Quality Unit to focus more resources on upstream risk mitigation through refined risk-stratification processes, targeted technical assistance, and data-informed performance expectations.

In summary, mortality findings serve as a foundation for continuous system improvement. DHHS will apply this analysis to strengthen cross-committee review, direct focused remediation, and enhance HCBS oversight statewide; reinforcing DDA's commitment to ensure all individuals served through Nebraska's HCBS waivers receive safe, person-centered, clinically responsive supports aligned with federal health and welfare assurances.

SECTION 7: APPENDIX

Glossary of Terms

- **Comprehensive Developmental Disabilities (CDD) Waiver:** A specialized state-administered Medicaid waiver program providing comprehensive, residential and day services for eligible participants and developmental disabilities.
- **Crude Mortality Rate:** The total number of deaths within a specified population during a given period, divided by the total population and typically expressed per 1,000 individuals.
- **Developmental Disabilities Adult Day (DDAD) Waiver:** A Nebraska Medicaid waiver focused on providing daytime habilitation, community integration, and employment supports to adults with intellectual and developmental disabilities (I/DD).
- **Family Support Waiver (FSW):** A Nebraska Medicaid waiver designed to provide services—such as respite care, assistive technology, and family training—to help children and adolescence with developmental disabilities continue living safely with their families in their family home.
- **Fatal Five Plus:** A group of acute, highly preventable medical conditions commonly associated with excess mortality in the I/DD population, including aspiration, bowel obstruction, dehydration, seizure, sepsis, and GERD.