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Nebraska Quality Quarterly Mortality Report

Period: October 1, 2022 — December 31, 2022

Report Date: January 31, 2023

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Executive Summary

This quarterly report includes information from the Mortality Review process and the Critical Incident Management Process (CIMP).

Mortality Review Quarterly Profile Data

The Mortality Review process reviews the deaths of participants who received services at Beatrice State Developmental Center or in the community through an HCBS Waiver provider. The process, through ongoing review and data analysis, identifies trends and opportunities for improvement to promote the health, safety, and quality of care for participants and reduce the occurrence of potentially preventable deaths.

Areas of Concern

All deaths investigated in the 4th quarter of 2022

- *20 people (13.5%) who died were <50 years of age*
- *63 people (42.6%) had 1 or more falls in the 6 months prior to their death*
- *56 people (37.8%) had pre-existing Fatal Five Plus conditions*
- *36 recommendation letters were sent to providers. 10 letters recommended training of staff members to identify changes in health status. 7 letters recommended fall prevention action planning to address participants' needs when experiencing an increase in falls*

4th Quarter 2022 Mortality Profile

A total of **148** mortalities occurred during the 4th quarter of 2022 (October 1 through December 31, 2022), across all four waiver programs. This includes additional deaths that were not reported promptly to DHHS for inclusion in the monthly reports. Of the 148 4th Quarter mortalities, **9** (6% of investigated mortalities) were unexpected deaths, with **116** of the **148** mortalities still in process of review and pending expected/unexpected determination.

Of the **9** Unexpected deaths investigated in the 4th quarter, **four** (**4**) (**44%**) were participants receiving Comprehensive Developmental Disability (CDD) waiver services, **four (4) (44%)** were receiving Aging and Disabled (AD) waiver services.

Unexpected deaths are defined as deaths that occur without warning or are unanticipated. Examples may include such circumstances as a sudden cardiac arrest; choking; death of a participant who otherwise appeared healthy; death as a result of an accident, suicide, or homicide; death resulting from or related to neglect or maltreatment; a death which was otherwise unforeseen or untimely. A focus on unexpected deaths provides the opportunity to:

- identify the areas of concern;
- identify opportunities for improvement;
- develop intervention strategies;
- develop systemic improvement strategies;
- develop risk mitigation strategies, promote safety, support well-being, and avoid preventable adverse outcomes.

Fatal Five Plus Pre-existing Conditions

56% (5) of unexpected deaths investigated in the quarter had one or more of the Fatal Five Plus pre-existing conditions before death. The Fatal Five Plus conditions (aspiration, bowel obstruction, gastroesophageal reflux disease (GERD), dehydration, sepsis, and seizures) are considered preventable causes of death in people with intellectual/developmental disabilities or older individuals.

Treatable and Potentially Preventable Mortalities

Potentially preventable mortalities are defined as causes of death in people under the age of 70 years that can be mainly avoided through effective public health and primary prevention interventions (i.e. before the onset of diseases/injuries, to reduce incidence).

Treatable mortalities are defined as causes of death that can be mainly avoided in participants under the age of 70 years through timely and effective health care interventions, including secondary prevention and treatment (i.e. after the onset of diseases, to reduce case-fatality).

The purpose of tracking treatable and potentially preventable deaths is to identify areas of opportunity for improvement in access to and delivery of primary and secondary healthcare interventions for the populations we serve.

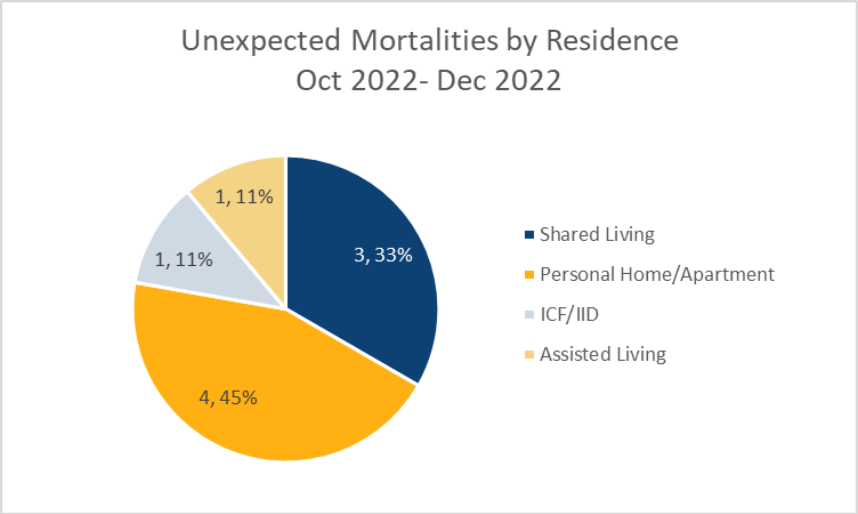
Within investigations completed for the quarter, there was **one (1)** mortality that was designated as potentially preventable and treatable and **eight (8)** mortalities that were designated as treatable.

The table below shows the treatable or preventable deaths that were also unexpected, with ages, causes of death, and noteworthy concerns related to the mortalities.

Treatable or Potentially Preventable Unexpected Deaths						
Age	**Residence**	**Cause of Death**	**Delay in Care**	**Level of Service Concern**	**Falls Before Death**	**Quality of Care Concerns**
21	Shared Living	Cardiac Arrest – Cause Unknown	Yes	No	None	Yes
57	Personal Home	Multiorgan System Failure	No	No	None	Yes
62	Shared Living	Complications of Hypertension and Heart Disease	Yes	No	1-5	Yes
27	Personal Home	Accident	No	No	1-5	Yes

Residential Setting at Time of Unexpected Death

This chart illustrates the number and percentage of unexpected deaths investigated during the 4th quarter per type of residential setting at the time of death.



- **Four (4)** of the **9 (45%)** unexpected deaths had quality of care concerns**. Two (2)** of these **4** lived in personal homes and the other two lived in shared living environments. **Two (2)** of these individuals had a delay in receiving urgent care due to a lack of caregiver recognition and/or training in the appropriate response to changes in the participant's health status.

Critical Incident Management Program (CIMP) Quarterly Profile Data

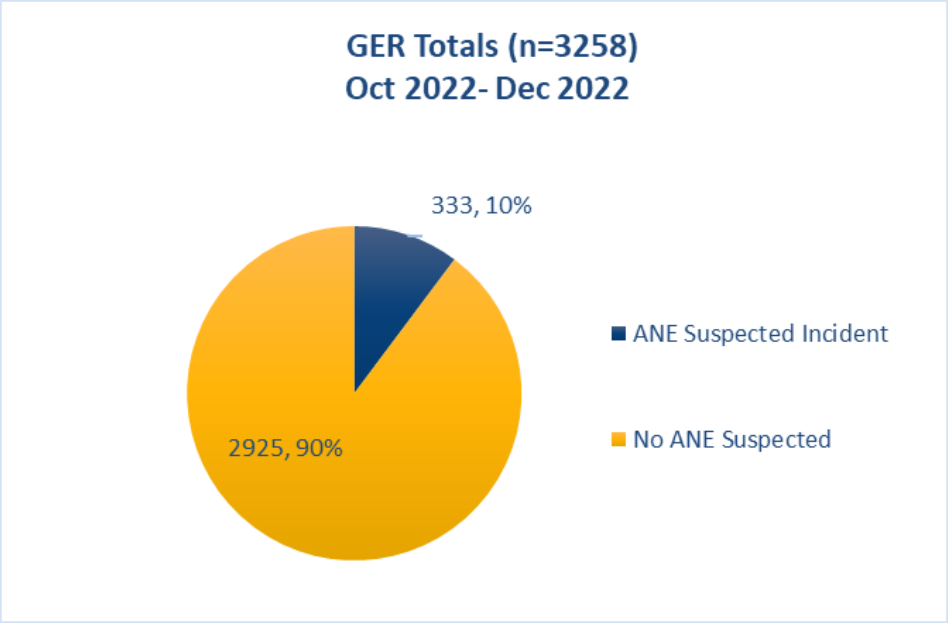
A total of **3258** General Event Reports (GER) involving **1426** total waiver participants were reported during the 4th quarter of 2022, within the Comprehensive Developmental Disabilities (CDD) and Developmental Disabilities Adult Day (DDAD) participants. In a comparison of data from the Therap Oversight GER Summary, and the Quality Information Data System (QIDS) review, it is important to understand that medium-level incident information inside of QIDS represents a 10% random sample of all mediums reported.

The chart below shows the total number of GERs and if Abuse, Neglect or Exploitation (ANE) was involved in the incident. There were **333** incidents of ANE for this quarter making up **10%** of all entered GERS for these waivers. Liberty reviews 100% of all ANE incidents.

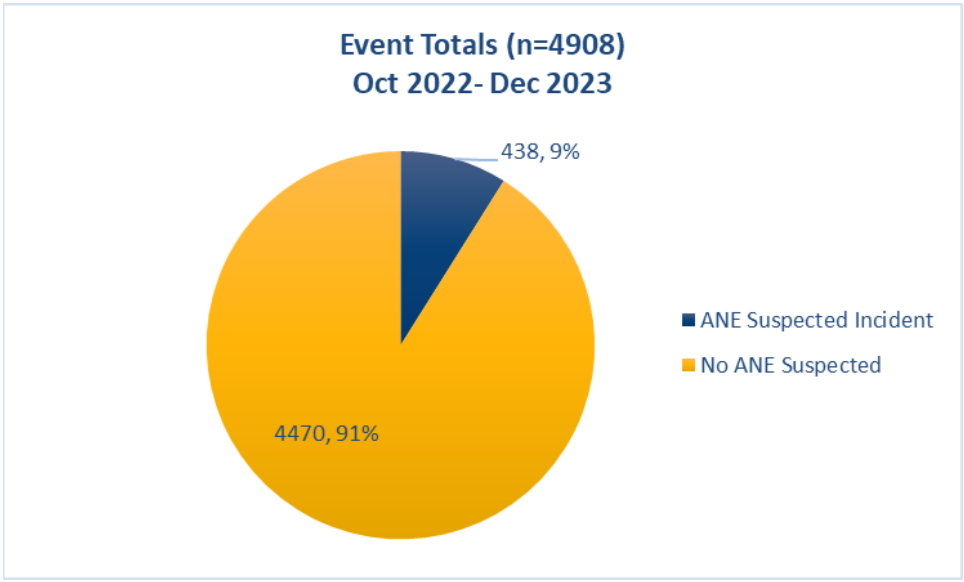
Areas of Concern

From 50 Targeted Analyses

- ***37%*** *of all Targeted Analysis action steps resulted in the need for the provider to create a procedure to ensure services were provided as required.*
- ***28%*** *of all Targeted Analysis action steps resulted in the need for additional training for provider staff.*
- ***9%*** *of all Targeted Analysis action steps required a health/mental health care evaluation or visit.*
- *Secondary to the findings of the Targeted Analyses, concerns with the training and utilization of emergency interventions were noted and addressed with DHHS-DDD.*



The graph below shows how many events are included in the **3258** GERs. As a note, multiple events may be included in a single GER due to the complexity of incidents. There were **4908** events total for this quarter.



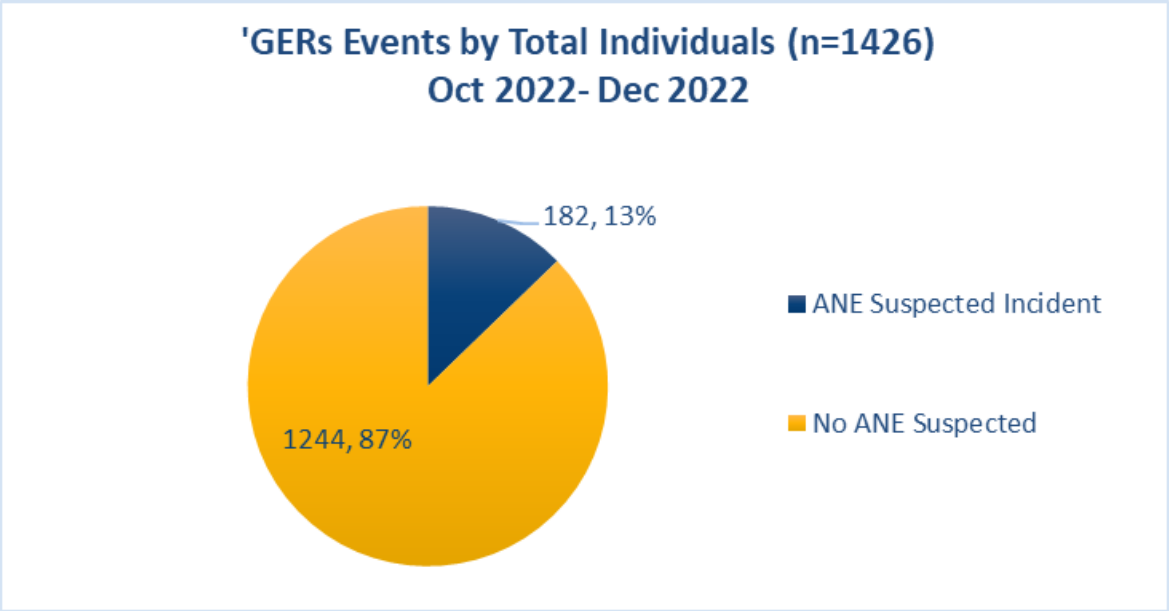
Below is a table that details the numbers associated with main event types in Therap.

GER Event Types	ANE Suspected Incident	No ANE Suspected	Grand Total
Injury	44	329	373
Medication Error	2	459	461
Other	388	3112	3500
Restraint Other	0	18	18

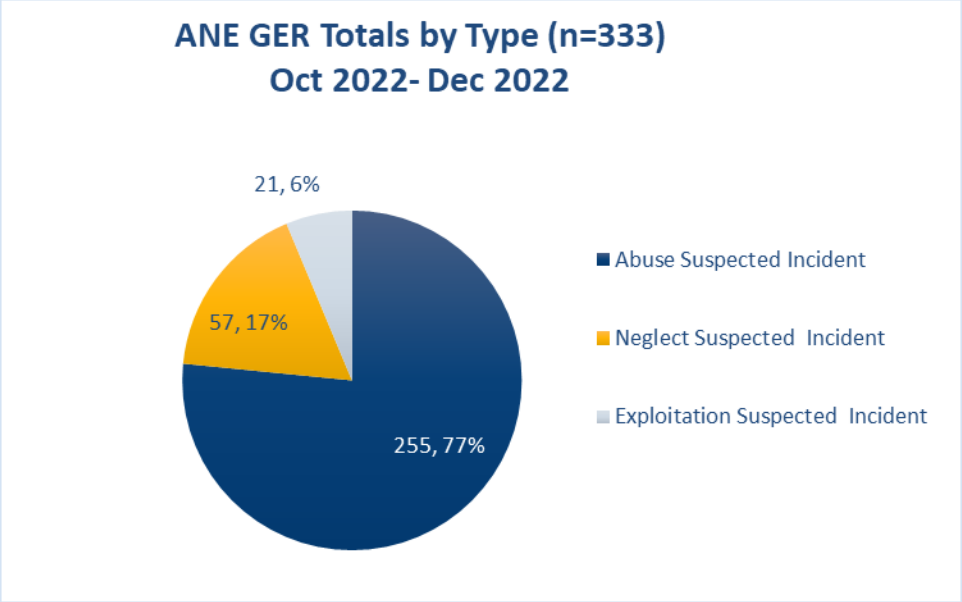
Emergency Safety Intervention	4	552	556
Grand Total	**438**	**4470**	**4908**

"Other" Category Sub-Types for Events	Total
Unplanned Hospitalization	727
Behavioral Issue	672
Misconduct/Possible Criminal Activity	468
Emergency Services Involvement	459
Abuse/Neglect/Exploitation.	330
Communicable Disease.	181
Property Damage	178
AWOL/Missing Person	139
PRN Psychotropic Use	56
Fatal Five	53
Fall without Significant Injury	47
Infestation	39
Swallowing In-edibles	32
Vehicular Accident	31
Fall with Significant Injury	25
Choking/Potential Choking	19
Displacement due to Emergency/Natural Disaster	18
Suicide Attempt	13
Prohibited Practice	13
Grand Total	**3500**

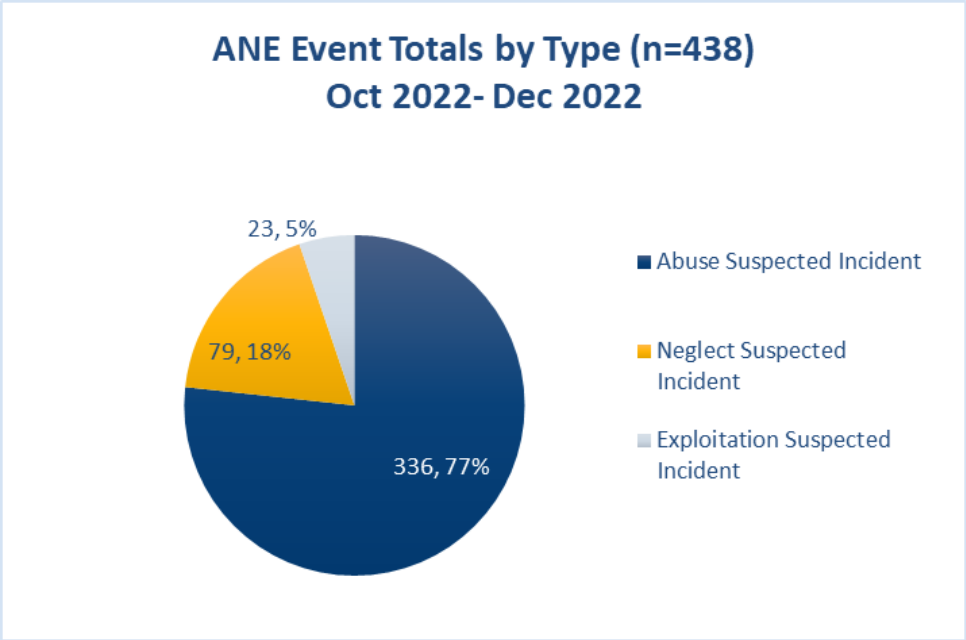
The graph below represents the total number of participants with a GER reported. Abuse, Neglect, and Exploitation events are depicted as ANE.



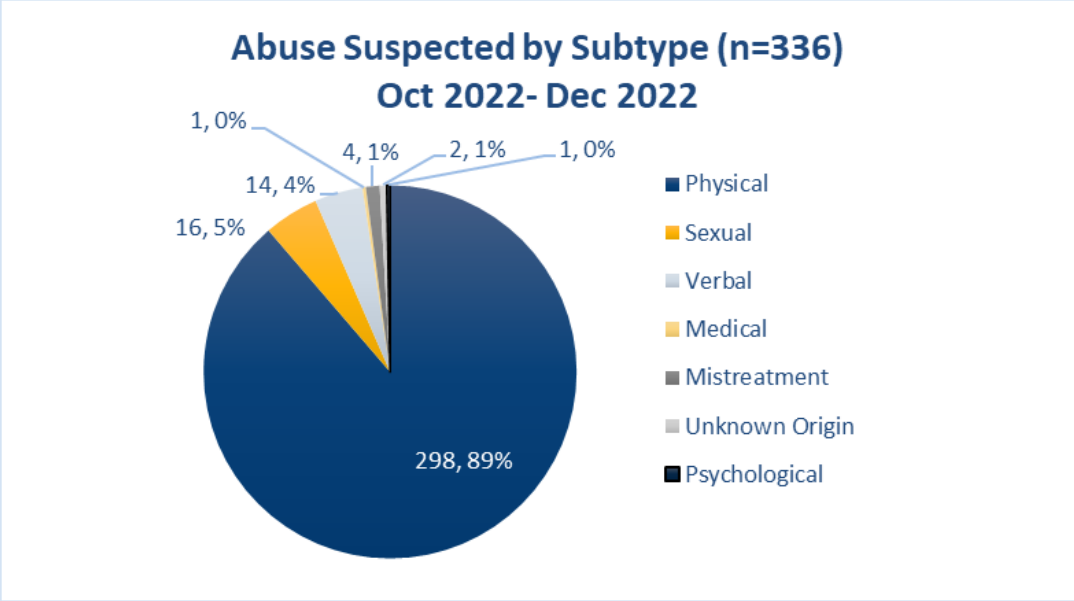
Abuse, Neglect & Exploitation Events



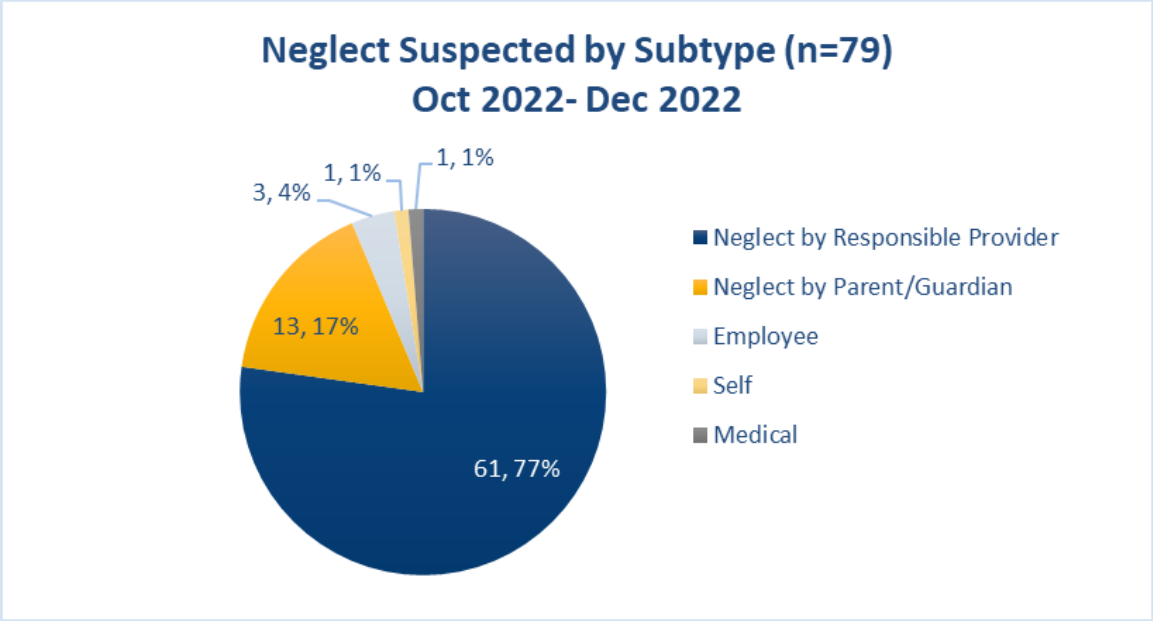
Therap Incident reports are referred to as General Event Reports (GER) and may include multiple events in one GER. The two graphs on this page represent total GERs marked as Abuse, Neglect, or Exploitation by GER total(above), and the total number of events by type of ANE (below).



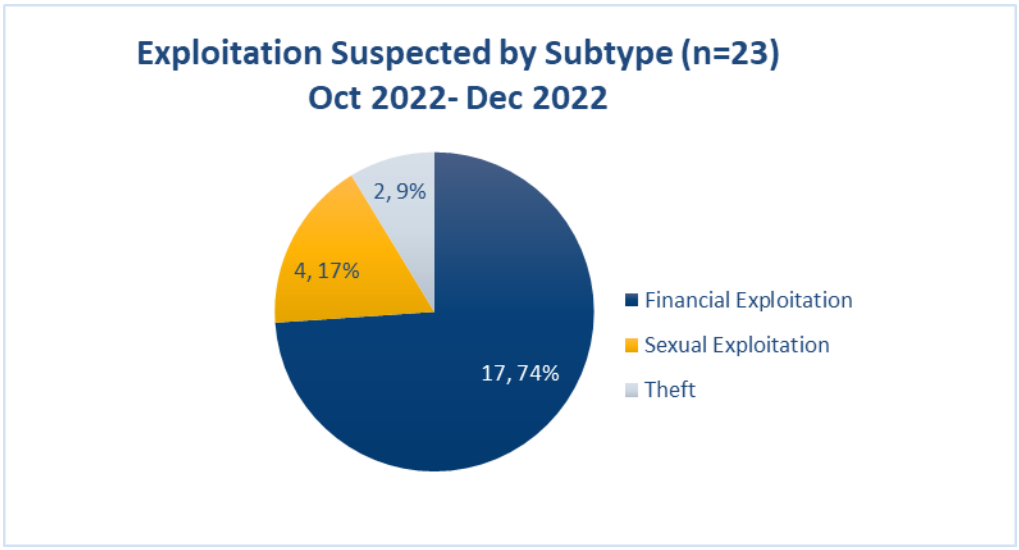
Of the **438** ANE Events for the 4th quarter, **77**% (**336)** were for abuse, which included the Subtypes below. Physical abuse accounts for two hundred ninety-eight **(298)** events, or **89%.**



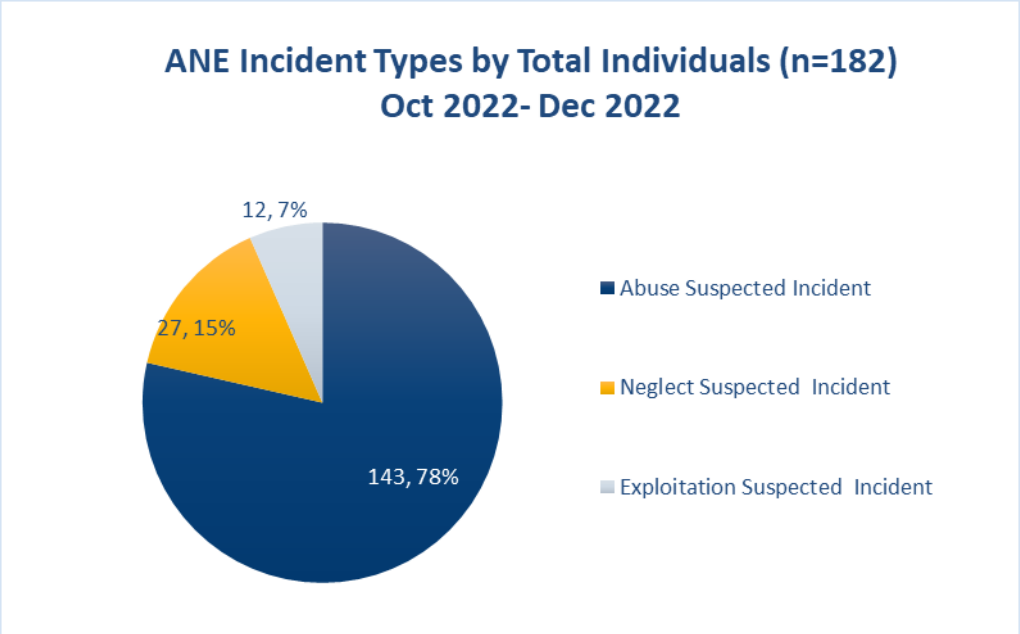
Of the **438** ANE Events for the 4th quarter, **18**% (**79)** were for neglect, which included the Subtypes below. Sixty-one **(61),** or **77%,** of all neglect events were due to neglect by responsible provider.



Of the **438** ANE Events for the 4th quarter, **5**% (**23)** were for exploitation, which included the Subtypes below. Seventeen **(17),** or **74%,** of all exploitation events were for financial exploitation.



182 people, or **13%** of individuals with high & medium-level GERs, were suspected to have experienced abuse, neglect, or exploitation. **9% (38)** of the participants who experienced abuse, neglect, or exploitation had 3 or more reports in the quarter, and **2% (8)** of the participants experienced 5 or more events of abuse, neglect, or exploitation.



In the future, we will add information about the perpetrators of the alleged abuse neglect, and exploitation incidents to further utilize data to determine action steps to prevent abuse. QIDS has been reviewed, and updates to QIDS are in development to supply this data.

Opportunities for Improvement

Review and analysis of the 4th quarter data collected from mortality reviews and CIMP have yielded several opportunities for improvement that inform our recommendations for systemic quality interventions:

- **Seven (5.3%) of the 132** mortality reviews that were completed during the quarter involved participants who had recent hospitalizations and returned to their previous services without documentation of a review of their post-hospitalization needs. For these seven people, there was an increased service need post-hospitalization and there was no documentation that these needs were addressed by the Services Coordinator.

  These mortalities were reviewed at Mortality Review Team (MRT) meeting or Mortality Review Committee (MRC) resulting in recommendation letters that addressed the need to assess the participant's discharge care needs to determine whether current services meet those needs. **10%** of critical incidents were for emergent care and unplanned hospitalizations. These findings would indicate the need for ensuring a successful transition at the time of hospital discharge to ensure appropriate services and training are in place to provide for the participant's healthcare needs.

- **Twenty-eight (28)** of the **132 (21.2%)** deaths reviewed resulted in recommendation letters due to concerns about unmet services or healthcare needs. Many of these gaps involved declines in health status that eventually exceeded current service provisions but were not recognized by Service Coordinators or were not addressed promptly and may have contributed to the unexpected death. **24** of these deaths were from the AD/TBI Waivers and **4** were from the CDD Waiver.

- Of the **132** mortality reviews completed in the quarter, **20** were unexpected deaths. Of those **20, 5 (25%)** had a fall within 30 days of their death. **One (1)** of the **9 (11.1%)** unexpected CDD

deaths had 1 or more falls within 30 days before death. While only **14** critical incidents in the quarter involved falls with injuries requiring care beyond just first aid, GERs currently include only CDD/DDAD waiver participants; AD Waiver participants would likely show much higher fall incidents if they were included in the data. This would suggest that education and protocols for fall prevention, and education for recognition of falls as a potential indicator of changing health status, should be a priority to improve services.

- Ten **(10)** of the 132 **(7.6%)** deaths reviewed resulted in recommendation letters due to the need for training of caregivers to meet the individual needs of participants. Two **(2)** of the **9 (22%)** unexpected CDD mortalities had recommendations issued for the need for training of caregivers to meet the individual needs of participants. **28% (35)** of targeted analysis action plan items involved additional training of individuals supporting participants.
- There were **448** reported medication error incidents in the 4th quarter. 5 reports were indicating medical intervention, but upon further review **100% (5)** were inaccurately recorded as reportable medication errors and medical intervention was unrelated to the omission of medication. Other medication error action plans submitted by the provider/agency did not indicate a robust investigation for systems or process issues was completed. This information indicates an opportunity to continue to support adherence to the incident reporting process and to ensure appropriate investigations are taking place to respond to medication error incidents.
- There were **124** critical incidents involving physical interventions. **4% (5)** of all reported physical interventions were prohibited practices as a result of administering a physical intervention when no emergency situation existed. Prohibited practices used in non-emergent situations represent human rights violations and increase the risk of injury for participants.
- Quality Assurance processes discovered issues with the Others at Risk (OAR) process. The QA data showed there was only **28.6%** compliance with the interpretation of the OAR criteria and risk remediation process during quality reviews of high and medium-level GERs. Education was provided to the Liberty Incident Review Specialists which resulted in an increase to **43%** in compliance with OAR criteria and risk remediation process quality reviews. Quality reviews completed following the internal Liberty education resulted in a marked increase in the identification of non-compliance with the OAR process by the Service Coordinators. Liberty Incident Review Manager will continue to closely monitor this indicator.

Recommendations and action steps designed to address these opportunities for improvement are described in the next section of this report.

Next Steps

4th Quarter 2022 Recommendations

The following recommendations are designed to address and correct the opportunities for improvement identified through analysis of the data from mortality reviews and the CIMP.

1. Develop DHHS-DDD clinical resources to assist service coordinators and providers to recognize and address gaps in health-related supports and services.
2. Increase knowledge and awareness of providers and service coordinators about the need to respond to and prevent participant falls incidents.
3. Develop a system within DDD to:
    a. Enhance minimum training requirements for providers & caregivers (base curriculum);

   b. Monitor compliance with training/education standards.
4. Develop a system for monitoring trends in medication errors by provider and address persistently high error rates for individual providers with clinical resource team technical assistance or targeted analysis.
5. Develop a system for monitoring trends in physical interventions by provider and participant and address persistent incidents of prohibited practices and high rates of physical intervention with targeted analyses.
6. Provide education to the Service Coordinators regarding the Others at Risk process used during GER triage.

Additional Discussion and Rationale for 4th Quarter Recommendations

Participant Health and Welfare Oversight

Provision and access to appropriate health-related services and support for participants in waivered service programs remain a challenge for the service delivery network, as evidenced by the data obtained from the review of mortalities of participants. Some of the instances of lack of those services and supports directly impacted the quality of life, and the deaths, of participants. Clinical support and health and welfare oversight of providers and participants is critical to assuring the health-related needs of vulnerable and often medically complex populations are assessed and addressed, particularly in the face of a lack of clinical support to providers of services who are independent providers or are providers too small to contract for nursing services.

DHHS-DDD already has clinical resources (nurses) whose functions could be re-evaluated and revised to remediate the health and welfare oversight challenges in the service delivery system. Nurses could assist service coordinators to evaluate changing health needs, assess and support transitions from acute care to supported living residential settings, evaluate and address medication administration issues, and work with Liberty Quality Specialists to provide and reinforce technical assistance and education to providers.

Enhancing Provider Capacity

Targeted Analysis data and Mortality Review data underscore the need to enhance provider capacity by assuring that providers of services receive basic health-related and person-centered services education to achieve better outcomes for participants. Liberty recommends a comprehensive review of the minimum provider education requirements for reimbursement for waiver services and the provision of education programs to meet those minimum requirements that include both initial and annual education requirements. Compliance with revised education requirements should be monitored more often than occurs with license renewal and recertification. Liberty recommends adding training documentation review to the Quality Onsite Provider Review tool that Liberty will use for provider onsite reviews. An example of this finding shows that **1** mortality review participant for December 2022 was involved in a significant abuse allegation in March 2022, before the pilot or implementation of the new Critical Incident process, where the participant was left at home with an untrained person identified as a natural support and previous guardian. In this incident, the participant was tied to her bed with a shoelace reportedly to keep the participant from pulling out her tracheostomy. At the time of death, this participant was left with the same person who reported they did not know what to do to respond to a medical emergency. This mortality indicates a missed opportunity to ensure proper support (training) to potentially prevent an unexpected death.

Also needing review are the platform(s) and methodologies for providing education to providers so that any barriers to participation in education programs are eliminated as much as possible. Provider education programs should be easily accessible, valuable, and relevant to both agency and

independent providers. Education programs that DHHS-DDD considers essential should be mandatory for providers so that DHHS-DDD can fulfill their responsibility to assure that providers are qualified to deliver high-quality services and supports to participants.

4th Quarter 2022 Mortality Review Process Summary

Overview of the Mortality Review Process

The Mortality Review process utilizes a mortality nurse investigator to review all mortalities, summarize case-specific findings, and make recommendations for quality improvements. Data is gathered from mortality review that is tracked, trended, and analyzed to identify opportunities for improvement in the quality of services designed to reduce or eliminate preventable deaths.

The Mortality Review Committee reviews aggregate data and the circumstances surrounding any unexplained or unexpected deaths bimonthly. The committee provides recommendations to improve systemic processes and strategic interventions to improve the quality of services, mitigate risk, reduce adverse outcomes, and promote positive participant outcomes. Providers are notified of case-specific recommendations to support performance improvement. In the coming year, remediation of mortality findings with providers will begin. Recommendation letters will change to finding letters and remediation verification will be added to the process.

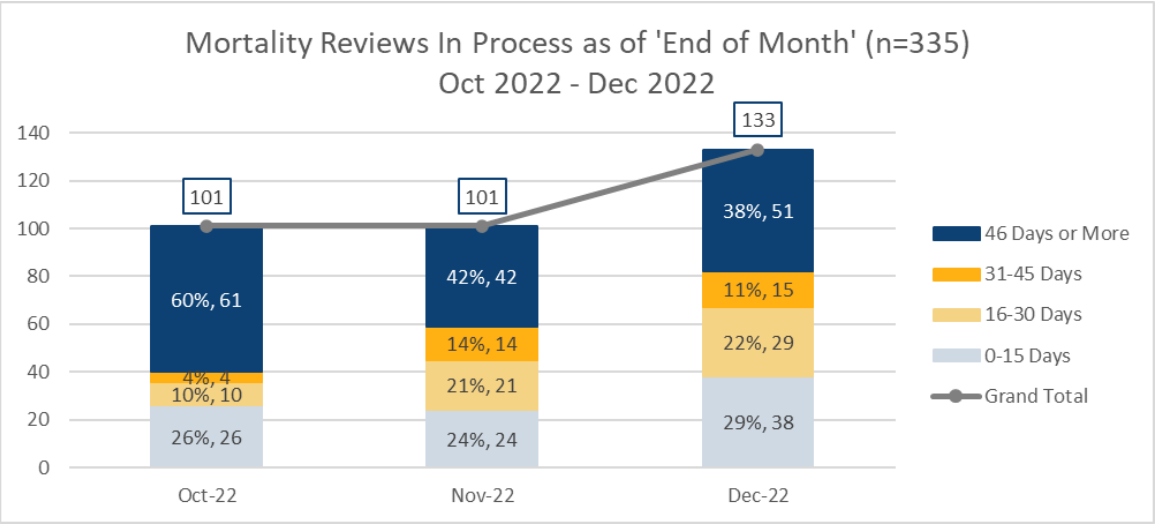
Recommendations are reviewed and considered by the Quality Improvement Committee quarterly. The Quality Improvement Committee then responds to the MRC with proposed next steps to address the recommendations.

4th Quarter 2022 Mortality Review Process Data

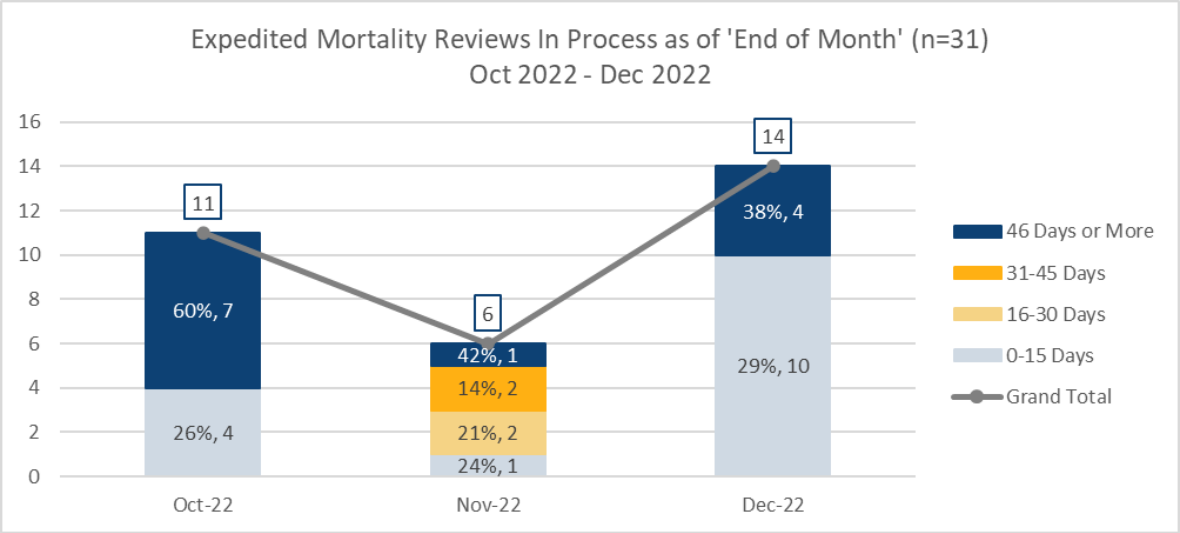
There were **145** mortality cases triaged during the 4th quarter, with **26 (18%)** cases that were categorized as *expedited*. Expedited cases are mortalities for which investigations must be completed within 45 days of triage. The triage process was refined in the 2nd quarter to include a more stringent inspection of circumstances of deaths, resulting in an increased number of expedited cases that were potentially unexpected mortalities.

There were **132** investigations completed in the 4th quarter of 2022.

This chart illustrates the number and aging of mortality reviews in process in October, November, and December of 2022.



This chart shows the expedited mortality reviews in the process in October, November, and December of 2022. The twenty-eight (28) expedited reviews in process longer than the 45-day completion requirement are still awaiting requested documents and/or cause of death to complete the reviews.



Mortality Review Committee Summary

The Mortality Review Committee (MRC) met on **November 21, 2022**, to discuss individual mortality review cases as well as to review and discuss mortality data analysis. In this meeting, the committee discussed a total of **five (5)** unexpected, unexplained, or mortalities that had identified concerns, and the MRC members also reviewed **fifteen (15)** additional cases before the meeting. As a result of the MRC mortality reviews, the committee made the following recommendations to the DDD QI Committee for systemic improvements:

- Quality Improvement Committee review and recommend that all Service Coordinators will be competency-based trained on the process of identifying changes in condition and follow-up on these changes in the participants they serve.
- Quality Improvement Committee should implement procedures involving the communication and implementation of new medical orders and recommendations for direct care staff and agency medical professionals.
- Quality Improvement Committee implementation of processes for hospital discharge needs and evaluation of services provided to participants.
- Quality Improvement Committee staff competency-based training on facility protocols.
- Quality Improvement Committee should look at a standardized form for discharge regarding medical oversight when a person is discharged from a higher level of care including hospitalization and nursing home.

4th Quarter 2022 CIMP Process Summary

Overview of the CIMP Process

The Critical Incident Management Process utilizes Incident Review Specialists to review all high notification level GERs and 10% of medium level notification GERs entered into Therap for the CDD/DDAD waiver participants. Through the quality review process, data is tracked, trended, and analyzed to identify incidents or concerns that meet the DHHS-DDD Escalation criteria for targeted analysis.

The Targeted Analysis process encompasses a thorough investigation of causal factors to assist providers in identifying the root causes of incidents. Through this process, the Incident Review Specialist(s) work collaboratively with the providers and DHHS-DDD Service coordination to gather pertinent documents and other information to present data-driven evidence. Action plans are created and progress is tracked.

The Incident Management Committee (IMC) is under development at this time.

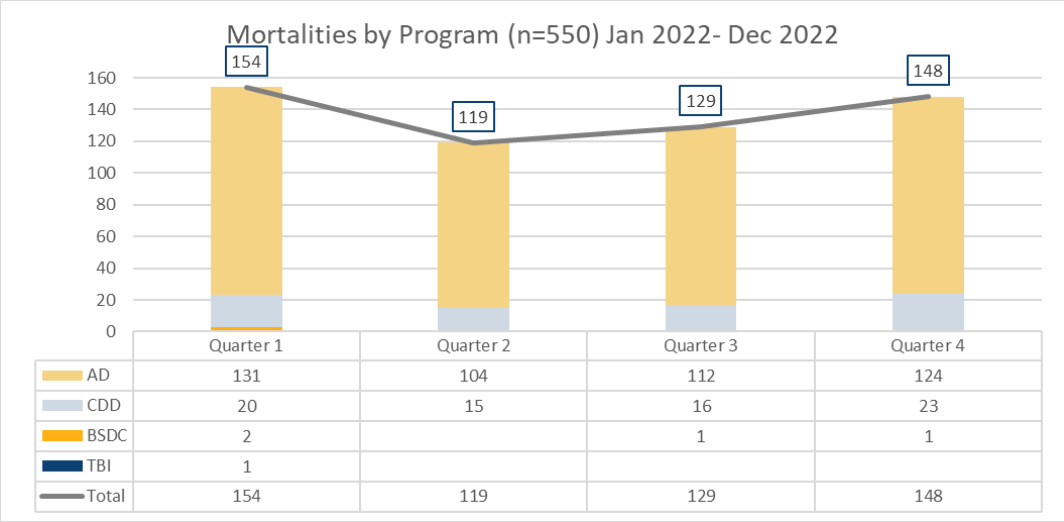
4th Quarter 2022 CIMP Process Data

A total of **1325** GERs (CDD/DDAD waiver participants) received quality reviews in the 4th quarter. **14% (465)** were high-level GERs and **86% (2793)** were medium-level GERs. Eight **(8)** of the **465** reviewed high-level GERs were for the Developmental Disability Adult Day (DDAD) Waiver while all remaining reviews **(457)** were for the Comprehensive Developmental Disability (CDD) Waiver.

Through data analysis, we have identified some areas for quality control improvement. The number of Incidents in QIDS compared to the number of incidents from the Therap Oversight GER Management Summary will vary, due to the number of non-waiver participants with GERs being entered. Currently, there is no efficient method for Liberty Healthcare to identify and remove non-waiver reports from the data. Furthermore, there are other discrepancies between the Therap Oversight Pulls and QIDS data. Liberty added this item to the agenda of the CIMP workgroup; however, an effective solution has not been identified. Liberty will continue to bring attention to this topic until resolved.

Additional Mortality Review 4th Quarter Data

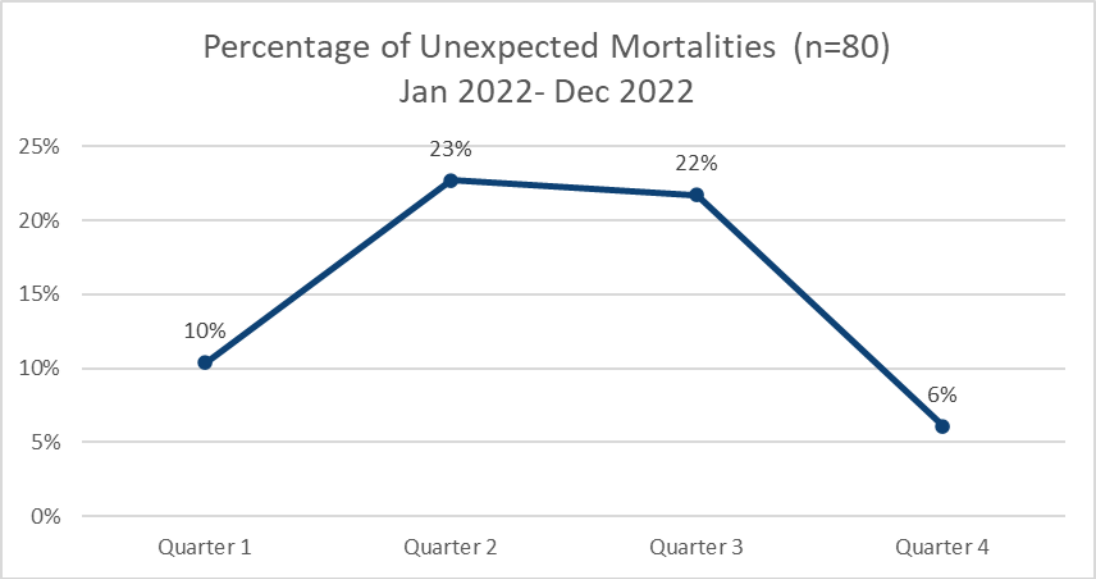
Mortalities by Waiver Program

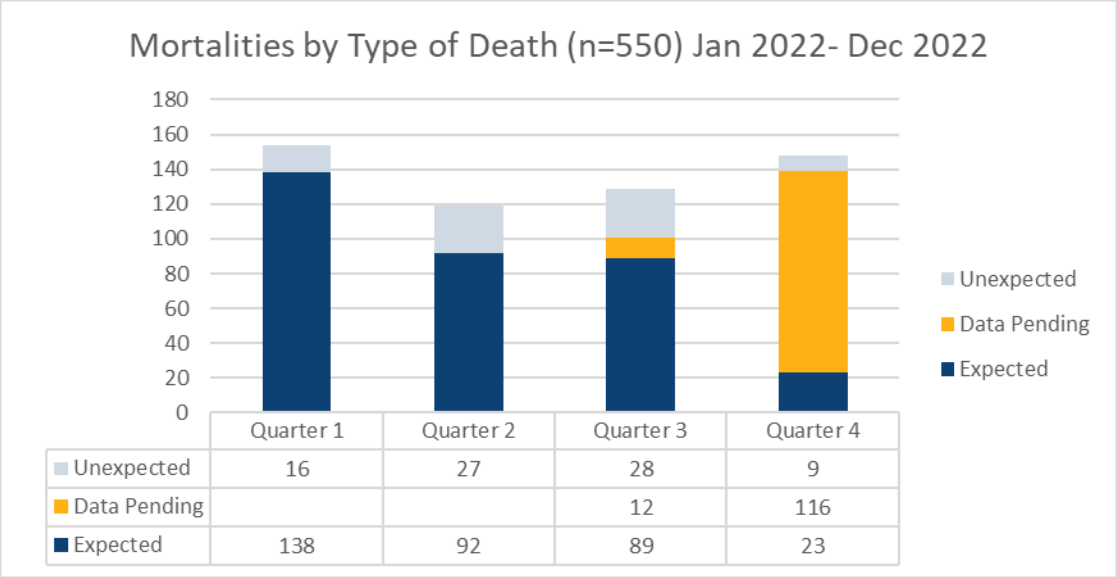


	Quarter 1	Quarter 2	Quarter 3	Quarter 4
AD	131	104	112	124
CDD	20	15	16	23
BSDC	2		1	1
TBI	1			
Total	154	119	129	148

Unexpected and Expected Deaths

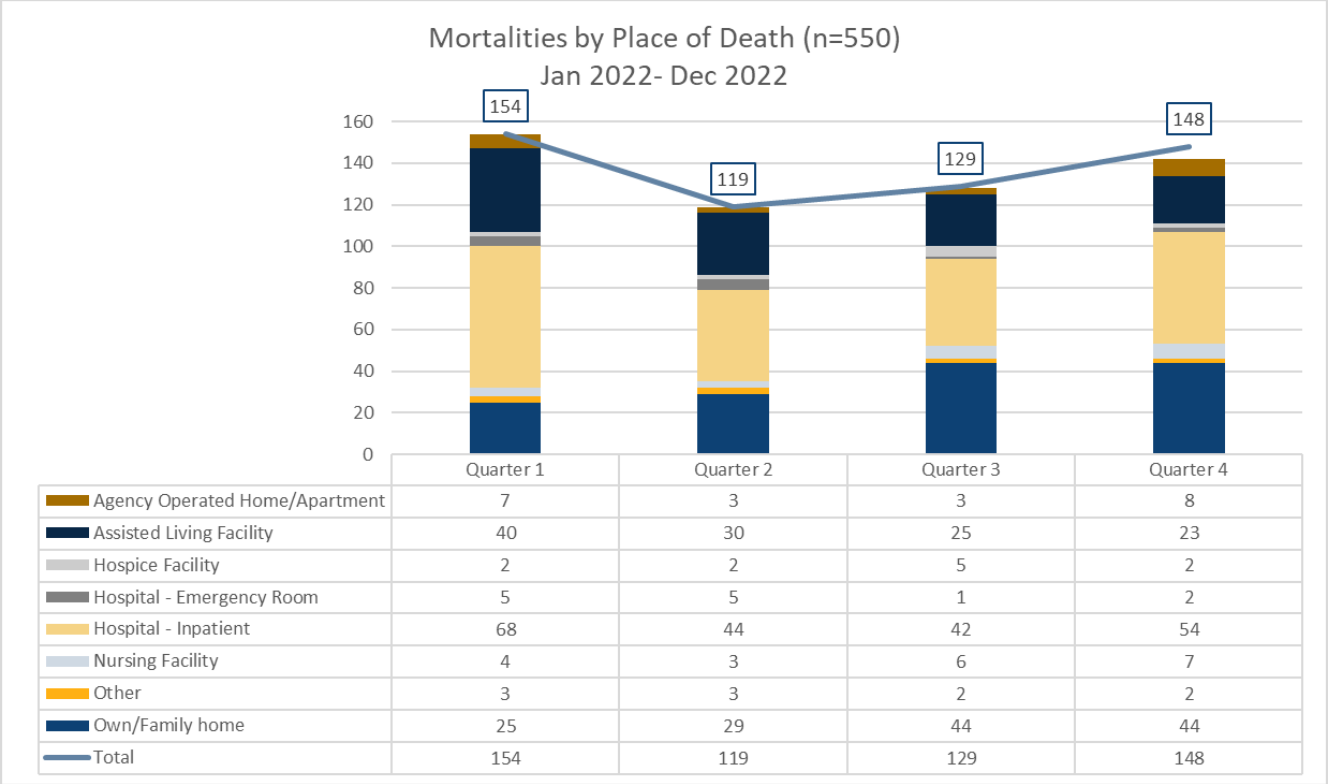
This chart compares the percentage of unexpected deaths for the previous four quarters. Mortalities are often classified on initial notifications of death as “expected.” This designation is sometimes changed to “unexpected” following the mortality review based on review criteria, so the original expected/unexpected designation on the notice of death is not considered reliable.



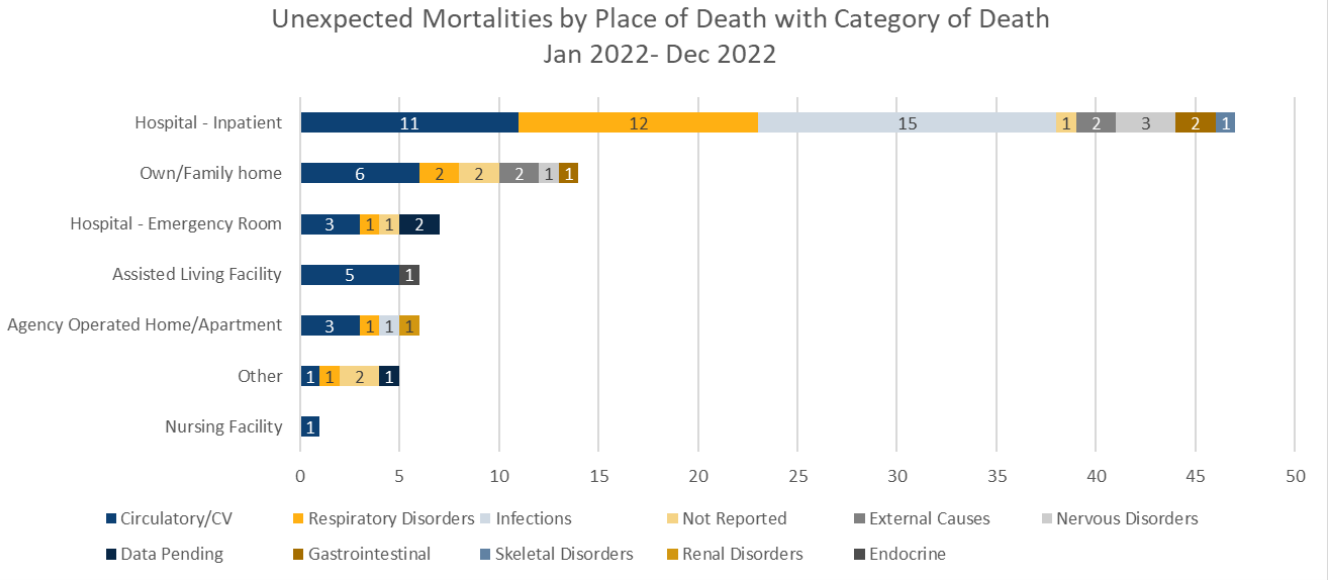


	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Unexpected	16	27	28	9
Data Pending			12	116
Expected	138	92	89	23

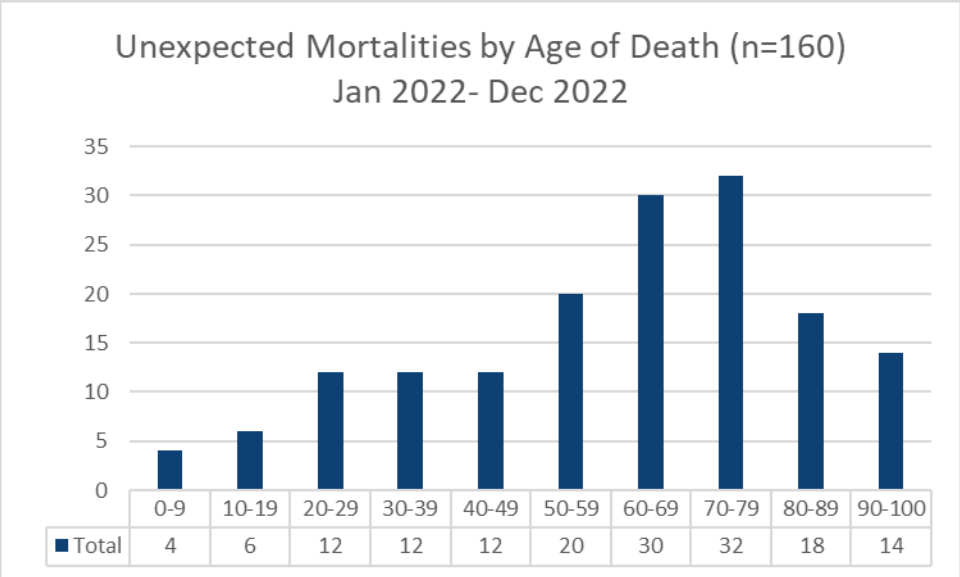
Mortalities by Place of Death



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Agency Operated Home/Apartment	7	3	3	8
Assisted Living Facility	40	30	25	23
Hospice Facility	2	2	5	2
Hospital - Emergency Room	5	5	1	2
Hospital - Inpatient	68	44	42	54
Nursing Facility	4	3	6	7
Other	3	3	2	2
Own/Family home	25	29	44	44
Total	154	119	129	148



Unexpected Mortalities by Age



Mortalities by Category of Death

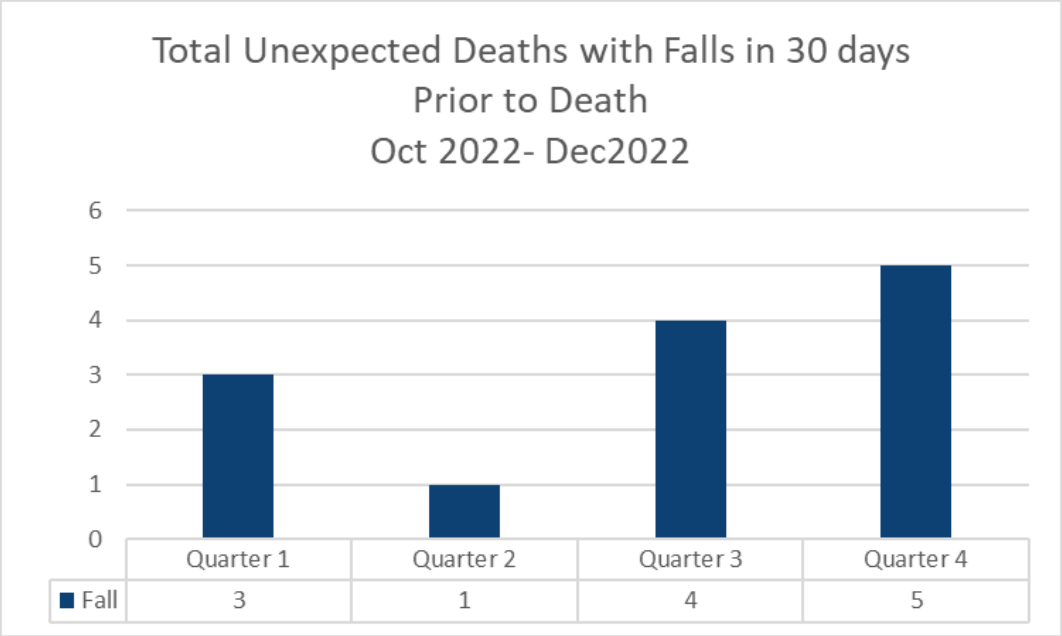
Category of Death for Unexpected Deaths Jan 2022- Dec 2022					
Category of Death; Subcategory	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**	**Grand Total**
Circulatory System/Cardiovascular System Disorders	**5**	**9**	**13**	**2**	**29**
Circ/CV: Atherosclerosis	0	0	1	0	1
Circ/CV: Cardiac Arrest/Cardiorespiratory Arrest	3	5	5	1	14
Circ/CV: Condition	0	2	3	1	6
Circ/CV: Congestive Heart Failure	0	0	1	0	1
Circ/CV: Heart Attack (Myocardial Infarction)	2	1	2	0	5
Circ/CV: Sudden Cardiac Death	0	1	1	0	2
Endocrine System Disorders	**0**	**0**	**0**	**1**	**1**
Endo: Diabetes	0	0	0	1	1
External Causes	**1**	**2**	**1**	**0**	**4**
External: Accidents-motor vehicle, pedestrian	0	0	1	0	1
External: Choking/Asphyxiation	1	2	0	0	3
Gastrointestinal/Digestive System Disorders	**1**	**1**	**1**	**0**	**3**
GI/Digestive: Bowel Obstruction	1	0	0	0	1
GI/Digestive: Condition not otherwise specified	0	1	1	0	2
Infections	**5**	**4**	**3**	**1**	**13**
Pneumonia	1	1	0	1	3
Sepsis	3	3	3	0	9
Urinary tract infection	0	0	0	0	0
Viral: COVID-19	1	0	0	0	1

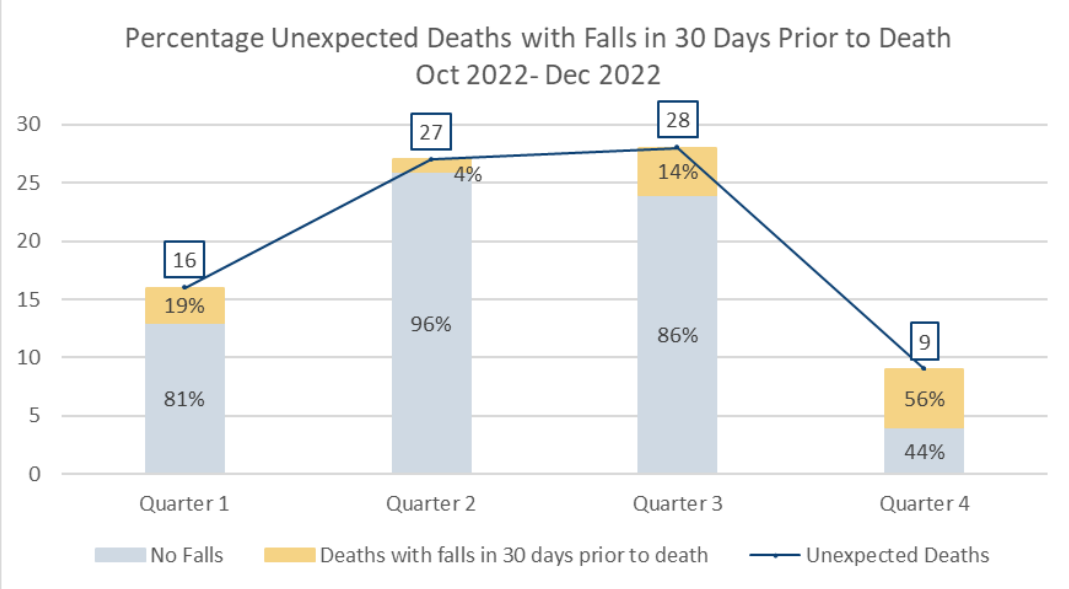
Not Reported	**0**	**1**	**1**	**4**	**6**
Nervous System Disorders	**1**	**1**	**1**	**1**	**4**
Nervous: Encephalopathy	1	0	0	0	1
Nervous: Not otherwise classified	0	1	1	1	3
Data Pending	**0**	**1**	**2**	**0**	**3**
Renal System Disorders	**0**	**1**	**0**	**0**	**1**
Respiratory System Disorders	**3**	**7**	**5**	**0**	**15**
Respiratory – Condition	1	1	1	0	3
Respiratory – Failure	2	5	3	0	10
Respiratory – Infection	0	1	1	0	2
Skeletal System Disorders	**0**	**0**	**1**	**0**	**1**
Bone and joint disorder	0	0	1	0	1
Grand Total	**16**	**27**	**28**	**9**	**80**

Unexpected Mortalities by Residence at Time of Death

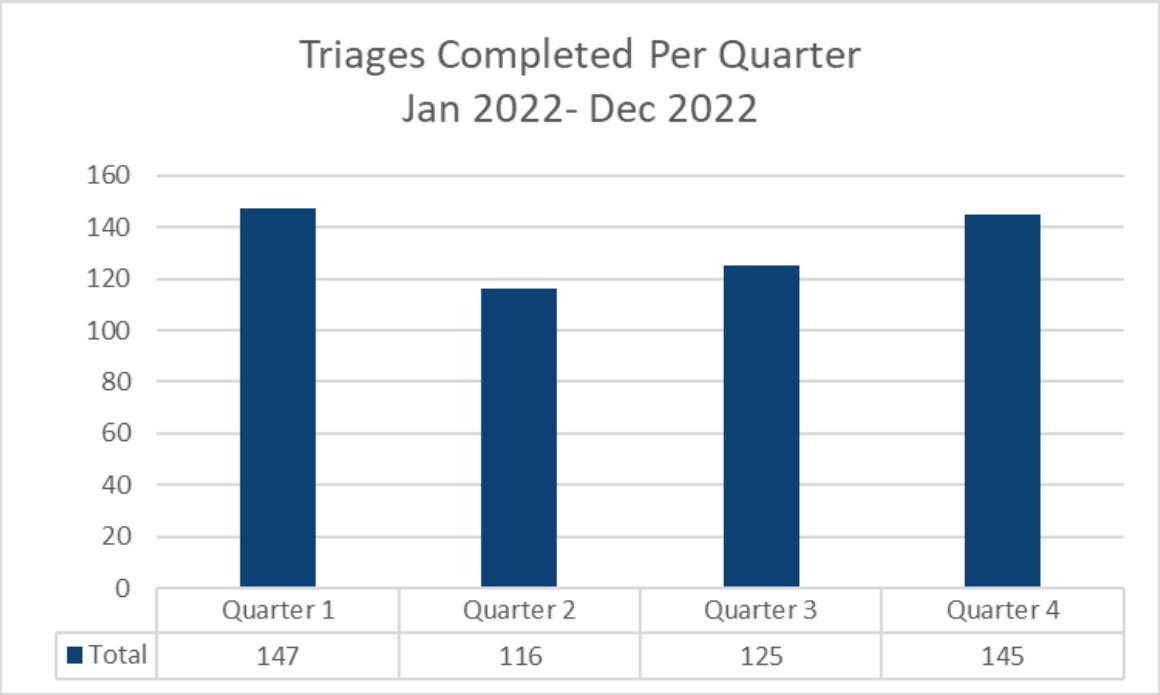
Residence at Time of Death	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Unexpected Deaths Grand Total
Personal Home/Apartment	3, 8%	12, 32%	18, 49%	4, 11%	37
Shared Living	6, 33%	5, 28%	4, 22%	3, 17%	18
Assisted Living	3, 18%	7, 41%	6, 35%	1, 6%	17
Group Home	2, 40%	3, 60%	0	0	5
ICF/IID	2, 67%	0	0	1, 33%	3
Unexpected Deaths Grand Total	**16, 20%**	**27, 34%**	**28, 35%**	**9, 11%**	**80**

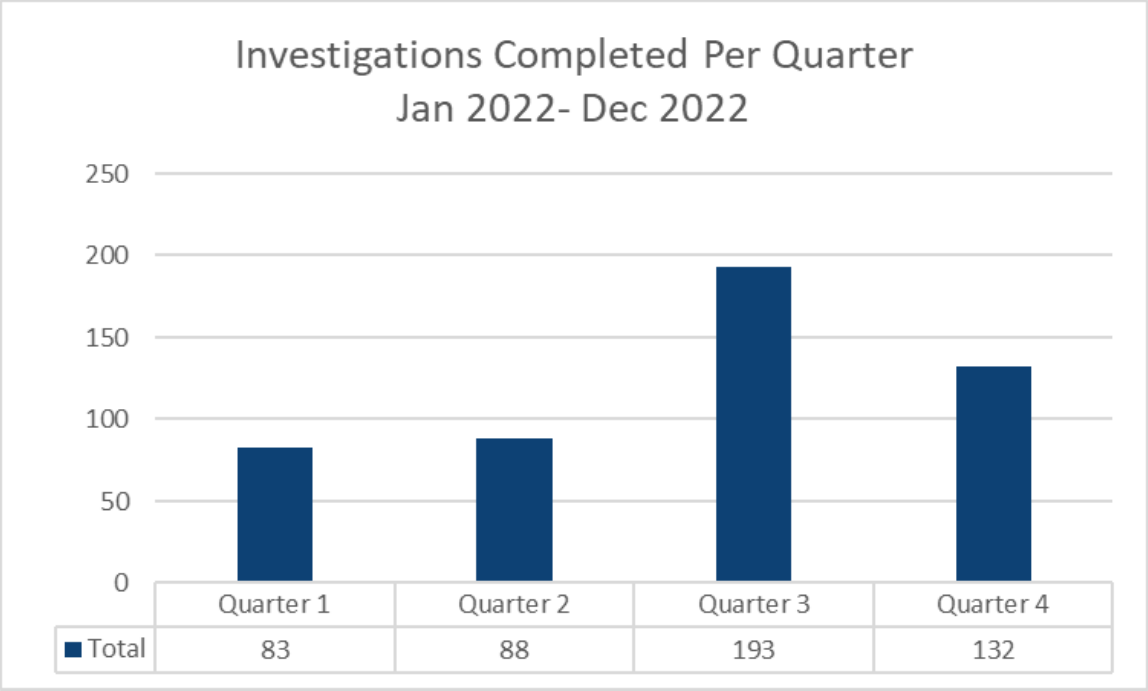
Unexpected Mortalities and Falls





Mortality Review Process Data

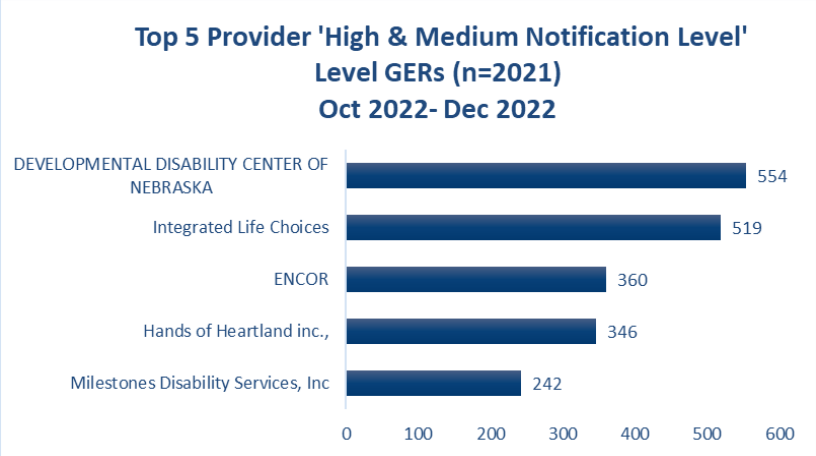


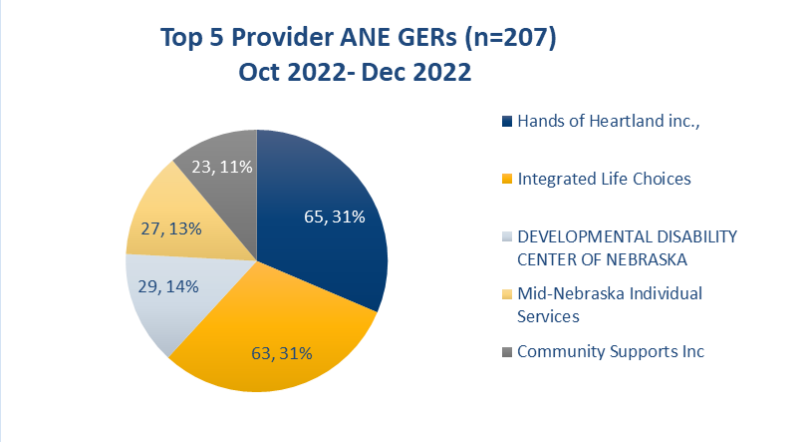


Additional CIMP 4th Quarter Data

CIMP Provider Data Summary

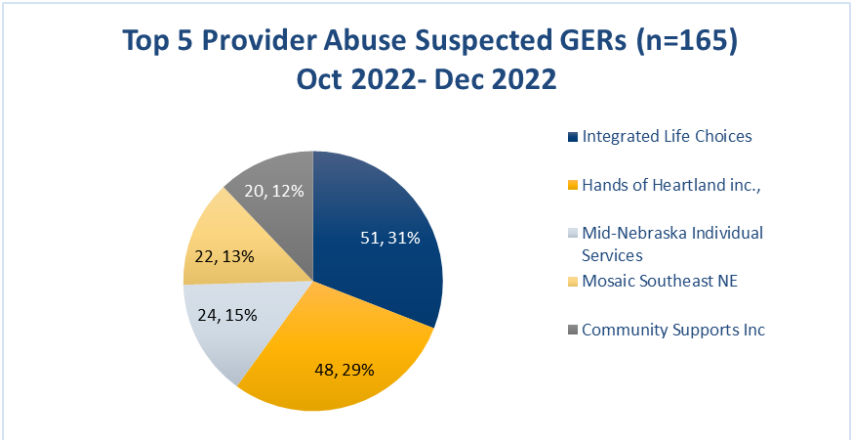
For the 4th quarter of 2022, the top 5 providers entered **62**% **(2021)** of all high and medium notification incident reports. In future reports, we plan to include a rate of incidents per provider to factor in the number of people that each provider supports.



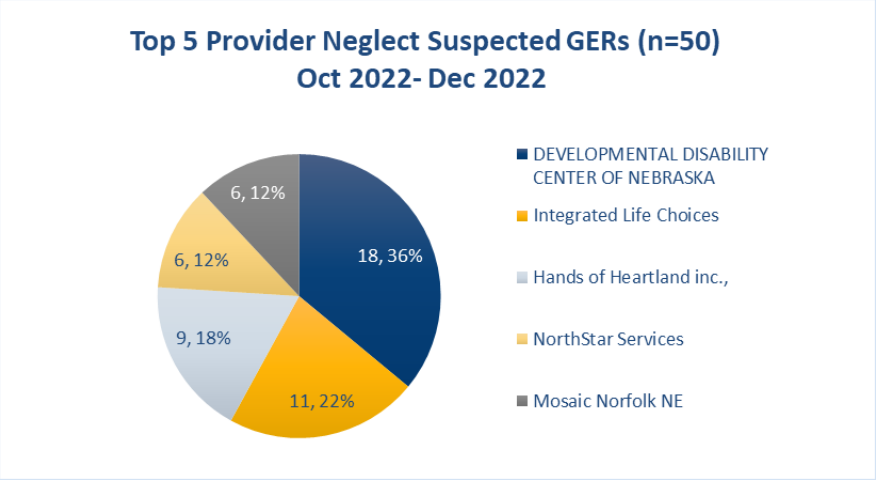


The chart to the left shows the numbers of abuse, neglect, and exploitation events per the top providers.

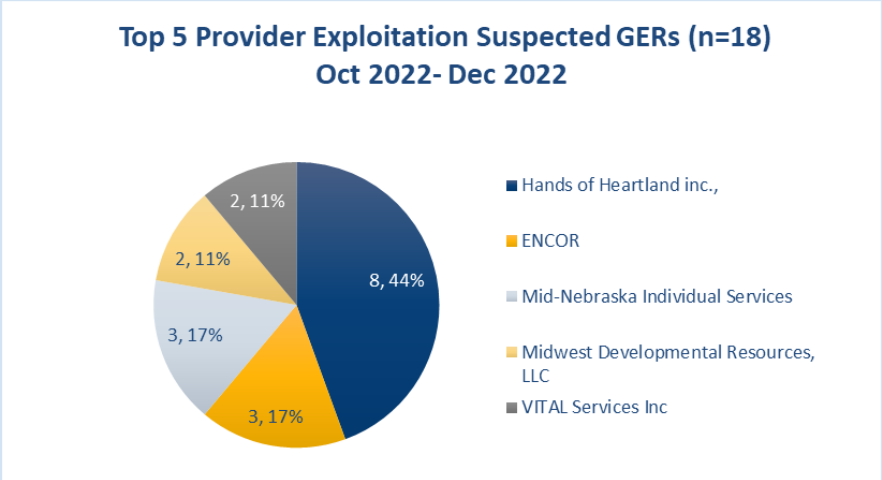
For incidents in which abuse is suspected, **5** providers were listed. Integrated Life Choices appears on the Top 5 list for abuse and neglect and has been on the top provider list since the implementation of the CIMP monthly reports (October 2022). Hands of Heartland, Inc. appears on the Top 5 list for abuse, neglect, and exploitation GERs.



5 top providers had **6** or more GERs involving a neglect allegation.



There were five providers with **2** or more Exploitation Suspected GERs for the 4th Quarter.



- **Hands of Heartland inc.** was in the Top 3 Providers in all 3 ANE Categories
- **Integrated Life Choices** was in the Top 3 Providers for 2 of the 3 ANE Categories

CIMP Provider Data Quarter Rate (Top Ten)

Provider Name	Quarter GER Count	Avg. Active Individual Count	Rate (GERs/Partic.)
MIDWEST PIONEER SUPPORT AND SERVICES, LLC	2	1	2.0
DEVELOPMENTAL DISABILITY CENTER OF NEBRASKA	94	102	0.92
KVC NE	18	34	0.53
TOGETHER EVERYONE ACHIEVES MORE (TEAM), LLC	14	27	0.52
LEADING MOTIVATING DEVELOPING SERVICES LLC	1	2	0.5
COMPASSIONATE SERVICES AND CONSULTING LLC	13	29	0.45
UNION FOR HELPING AND SUPPORTS, LLC	10	25	0.4
HEARTLAND HABILITATIVE SERVICES, LLC	10	27	0.37
MIDWEST DEVELOPMENTAL RESOURCES, LLC	1	3	0.33
OMNI BEHAVIORAL HEALTH - LINCOLN	13	40	0.33

Developmental Disability Center of Nebraska (DDCN) had the second highest provider rate for GERs entered into Therap at **0.92**, a Targeted Analyses rate of **0.09**, and also had the participant with the highest number of GERs for the quarter. It is recommended that this provider receives increased oversight and monitoring due to these indicators.

CIMP Participant Data Summary

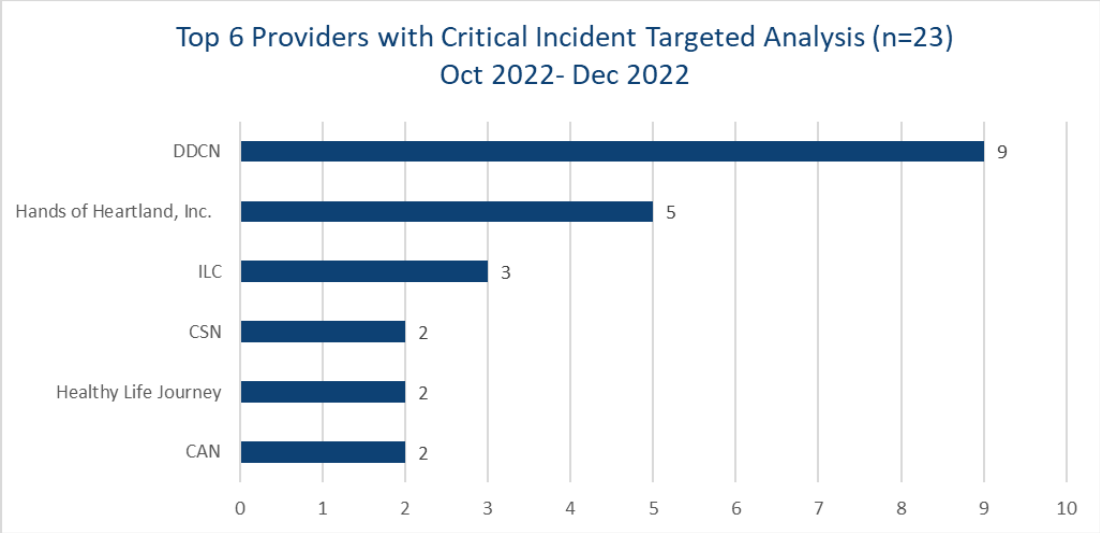
The table below shows the top 4 participants by the total number of high and medium-level incidents. There are an additional **28** CDD/DDAD waiver participants with 10 or more GERs for the quarter. They are not represented on this graph due to the number of participants with identical total numbers.

Participants 1 and 3 were involved in Targeted Analyses in Quarter 4. All providers represented in the Top 4 had at least 1 targeted analysis completed in Quarter 4.

Individual (NFOCUS ID), Provider	Total GERs
Participant 1 (97943309)	**26**
Developmental Disability Center of Nebraska	26
Participant 2 (92887392)	**22**
Hands of Heartland Inc.	22
Participant 3 (67553491)	**20**
North Platte Opportunity Center	20
Participant 4 (45606653)	**20**
Together Everyone Achieves More, LLC	20

CIMP Targeted Analysis Data

In the 4th Quarter of 2022, **50** targeted analyses, were completed for **33** providers. DCCN had **9** targeted analyses done, while Hands of Heartland, Inc. had **5**. ILC had **3** target analyses done. CAN, CSN, and Healthy Life Journey each had **2** completed over the quarter, while the remaining **27** each had one target analysis completed. This information was extracted based on the providers naming conventions in Therap and may cause data issues in the future.



From those **50** targeted analyses, **207** total action plan steps were implemented. The two action plan types with the highest frequencies were **to write a procedure (45 or 22%) and other (29 or 14%).**
Other items included developing plans to align with person-centered planning, conducting activities to ensure appropriate staffing, developing a system to capture staff responsibilities/assignments, scheduling and ensuring completion of a Functional Behavior Analysis /Behavior Support Plan, ensuring GER reporting and resolution activities are completed per DHHS-DDD guidelines, and completing activities in compliance with the Critical Incident Management Process. The table at right shows the areas where the most recommendations were made.

Topic	Total from (50) Target Analyses
Write a Procedure	45
Other	29
Education For Staff	25
ISP Team Meeting to Update ISP	16
Medical/Mental Health Visit/Evaluation	11
Update FBA/BSP	11
NULL	9
Update Form	9
Education For Participant	8
Create Form	7
Training	6
Physical Environment Change	6
Protocol Development	6
Modify Current Procedure	5
Modify Current Policy	4
General Retraining	3
Personnel Action	2
ISP Training	2
Advocacy	1
Update Healthcare Plan in ISP	1
Update Committee Structure	1
Grand Total	**207**