

The background features a blurred image of a person in a hospital bed, overlaid with a green geometric pattern of lines and various medical icons such as a syringe, a pill, a stethoscope, and a group of people. A large white cross is centered over the person's chest.

Nebraska Department of Health and Human Services

Adult Facility System
Redesign Report

Updated November 19, 2021



**MYERS AND
STAUFFER** L.C.
CERTIFIED PUBLIC ACCOUNTANTS



Table of Contents

■	Table of Contents.....	2
●	Table of Tables.....	3
●	Table of Figures	3
■	Executive Summary.....	4
■	Introduction	5
●	Why Redesign?	6
●	Redesign Methodology and Data Used.....	8
	AFCA Brief Summary.....	8
■	Redesign Elements.....	9
	Step 1 – Assess Population Needs (Level of Care).....	9
	Step 2 – Assess Structural Capacity and Licensing Requirements.....	9
	Step 3 – Redesign or Develop Programs to Meet Population Needs.....	10
	Step 4 – Develop Administrative and Operational/Facility Resources to Support Program Needs.....	10
■	System of Care for Older Adults	12
	Develop an Assessment Process for Older Adults that Spans All Available Service Needs Regardless of Current Placement.....	14
	Develop a Skilled Nursing Unit for Patients Who Cannot be Placed in the Community.....	14
	Look to Develop Existing Community Capacity and Partnerships.....	14
	Rethink Communications to Community-Based Providers	15
●	Implementation Considerations.....	15
■	System of Care for Forensic Patients.....	17
	Assess the Treatment Needs of Individuals Ordered to be Restored to Competency.....	17
	Redesign or Develop Forensic Programs to Meet Population Needs	18
	Work with the State Court Administrator to Improve Restoration Process	19



- Implementation Considerations..... 20
- System of Care for Sex Offenders 22
 - Leverage the Risk-Needs-Responsivity Model for Sex Offender Patients..... 22
 - Assess Facility Structural Capacity and Licensing Requirements 22
- Summary 26

Table of Tables

Table 1. Population and Service Needs..... 13

Table 2. Older Adults Implementation Tasks..... 16

Table of Figures

Figure 1. Order of Operation Framework 7

Figure 2. Facility Change Process 11

Figure 3. Continuum of Forensic Services..... 18



Executive Summary

The Nebraska Department of Health and Human Services (DHHS) contracted with Myers and Stauffer LC (Myers and Stauffer) to develop a plan to redesign the state's three state-operated adult facilities, which includes Beatrice State Developmental Center (BSDC), an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IDD), and two state psychiatric hospitals, Lincoln Regional Center (LRC), and Norfolk Regional Center (NRC).

DHHS seeks to identify opportunities that will further advance the focus and services provided by these facilities into settings and programs that are responsive to the current needs of Nebraska's most vulnerable populations and sustainable for future generations.

This redesign plan draws from several of the findings included in the *Draft Adult Facility Comprehensive Assessment (AFCA)* report and provides an outline for DHHS and the State to continue its work to transform the delivery of institutional and residential care, when appropriate, to meet patient care needs. The AFCA report includes observations and recommendations about how to strengthen the operation of the three facilities, ranging from administrative structure, staff recruitment and retention, and physical plant needs. It also discusses the treatment and programming needs of the populations served at each of the three facilities, which include:

- *Individuals with IDD who have complex medical and behavioral needs who cannot be easily or cost-effectively served in an alternative setting.*
- *Individuals who have been civilly committed.*
- *Individuals committed for restoration to competency to stand trial or competency evaluation.*
- *Individuals who have been civilly committed for sex offender treatment.*

This system redesign plan tackles three key issues that affect each of the three facilities: 1) development of an older adult system of care; 2) development of a forensic system of care; and 3) development of a sex offender system of care. It begins with an assessment of the treatment needs of the populations, which will help to shape and define program needs. Once program needs are identified, operational, physical plant, and infrastructure strategies may be developed accordingly.



Introduction

DHHS contracted with Myers and Stauffer to develop a plan to redesign the state's three state-operated adult facilities, which include BSDC, an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IDD), and two state psychiatric hospitals, LRC and NRC.

Previous analyses, ongoing initiatives, a fresh documentation review, and stakeholder interviews firmly establish BSDC as a critical safety net service provider within Nebraska's IDD service continuum. BSDC is operated by the Division of Developmental Disabilities and provides high-quality, specialized care and comprehensive residential and crisis stabilization services to individuals with IDD who have complex medical and behavioral needs that cannot be easily or cost-effectively served in an alternative setting. And while BSDC now operates as two ICFs, care, along with needed services and supports, is delivered in smaller, home-like settings, which offer residents considerable space and independence. Similarly, the Division of Behavioral Health (DBH) operates five adult programs across the two campuses of NRC and LRC. The programs include general psychiatry, medical services for patients with severe mental illness, forensic psychiatry, and three levels of the Nebraska Sex Offender Treatment Program. The populations are diverse, and patients range in age, levels of severity, sex, and level of care requirements.

DHHS seeks to identify opportunities that will further advance the focus and services provided by these facilities into settings and programs that are responsive to the current needs of Nebraska's most vulnerable populations and sustainable for future generations. DHHS has identified the following key principles for redesigning the three facilities:

- *Strengthen access to, coordination of, and consolidation of, services and locations.*
- *Improve integration of care for facility residents.*
- *Improve coordination of available resources to the needs of facilities and residents.*
- *Decrease fragmentation in the programmatic and administrative framework.*

Overlaying these redesign principles and consistent with the *Olmstead* decision, is DHHS's commitment to provide individuals with intellectual disabilities, serious mental illness (SMI), and behavioral health disorders the opportunity to live, work, and receive services in the most independent setting they choose, subject to their legal status (e.g., forensic patients and civilly committed sex offenders). The state of Nebraska has made considerable progress towards *Olmstead* implementation, and this redesign plan meshes with the goals and objectives of the state's active *Olmstead* Plan.

This redesign plan draws from several of the findings included in the AFCA report and provides an outline for DHHS and the State to continue its work to transform the delivery of institutional and



residential care, when appropriate, to meet patient care needs. The AFCA report includes observations and recommendations about how to strengthen the operation of the three facilities, ranging from administrative structure, staff recruitment and retention, and physical plant needs. It also discusses the treatment and programming needs of the populations served at each of the three facilities, which include:

- *Individuals with IDD who have complex medical and behavioral needs that cannot be easily or cost-effectively served in an alternative setting.*
- *Individuals who have been civilly committed.*
- *Individuals committed for restoration to competency to stand trial or competency evaluation.*
- *Individuals who have been civilly committed for sex offender treatment.*

As has been the evolution of safety net services in most states, the role of the three DHHS adult facilities has broadened to include provision of custodial care for older adult patients, many of whom have been long-term residents for whom alternative community placements were not feasible or successful due to their complex neurocognitive, functional, and behavioral health needs. For many of these long-term residents, patient psychiatric and IDD conditions have either stabilized or become secondary to Alzheimer's Disease, dementia, and other aging-related conditions. As with the general population whose average lifespan has grown, the life expectancy for adults with IDD and SMI has also grown over the last few decades due to medical advances and improved living conditions. The number of adults with IDD age 60 years and older is projected to nearly double from 641,860 in 2000 to 1.2 million by 2030.¹ The number of adults with SMI age 65 years and older has increased by 30% in the last ten years alone. 4.8% of the adult population has an SMI, including the growing aging population.² These patients often become a significant challenge for a state's health system. In addition, the number of adults arrested and convicted for the first time as older adults has significantly increased in the last decade and is occurring at a rate higher than younger age groups, which is further straining local courts and correctional facilities (Yarnell et al, 2017).³

Why Redesign?

As the findings of the AFCA report indicate, each DHHS facility, and the service delivery system of care overall, face significant challenges that may often negatively impact the ability to provide the best care possible. Some of these challenges are urgent, including for example, the recruitment and retention of

¹ <https://publications.ici.umn.edu/impact/23-1/people-with-intellectual-and-developmental-disabilities-growing-old-an-overview>.

² <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf>.

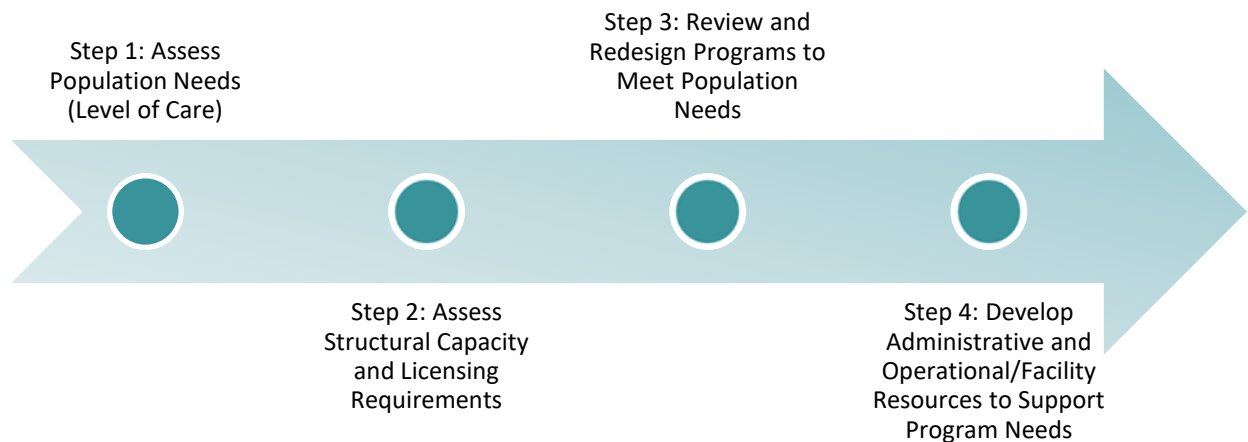
³ Yarnell, S., Kirwin, P., Zonana, H. 2017. Geriatrics and the Legal System. *The Journal of the American Academy of Psychiatry and the Law*. 45(2): 208-2017.



skilled and licensed direct care staff and a growing forensic wait list. There are long- and short-term steps involved in any redesign, and we recommend that DHHS begin by proactively addressing first those changes that are the easiest administratively to make and have the most impact. For example, NRC might plan for some infrastructure projects to modernize the facility (e.g., Wi-Fi installation), which can take years to fully implement, but in the short-term, current programming and services can and should be modified to best meet today’s facility populations. Other challenges faced by the facilities are, however, symptomatic of the changing populations; for instance the placement and care of older adults who no longer meet the requirements for continued inpatient stays.

To guide this redesign approach, we take a population-focused approach that is based on an order of operation framework. *Figure 1* shows the order of events required to successfully redesign these facilities to best meet the needs of the individuals served. This diagram summarizes the recommended redesign process that will guide this document.

Figure 1. Order of Operation Framework



This system redesign plan addresses three key issues that impact the three adult facilities: the development of an older adult system of care, the strengthening of the forensic system of care, and the sex offender system of care.



Redesign Methodology and Data Used

AFCA Brief Summary

DHHS engaged Myers and Stauffer to assess and develop recommendations for a comprehensive redesign of Nebraska's three state-owned and operated adult facilities, BSDC and the two state psychiatric facilities, LRC and NRC. The assessment phase of the project focused on central administration of facility and systems, administrative operations, programming within and across facilities, service delivery, and building operations and maintenance. It included developing recommendations based on findings from research, data, and stakeholder feedback. The AFCA report is the culmination of the first phase.

In developing the AFCA report, the Myers and Stauffer research team appraised the adult facility system to assess its status as part of the Nebraska state intellectual and developmental disability and behavioral health delivery landscapes. This involved compiling information and data specific to each of the facilities. We relied heavily on targeted stakeholder interviews to better understand the current organizational structure, priorities for review, known successes and concerns, and to obtain a deeper understanding of key goals and objectives. We then leveraged information provided through document requests to DHHS and additional research to deliver an assessment of strengths and challenges for each of the facilities. In some instances, we spoke with industry subject matter experts to provide perspective and best practice information to support recommendations.

The report details our assessment findings and provides redesign recommendations for the system administration, leadership, and each of the three facilities. The strengths, challenges, and barriers for each section were developed based on the process outlined in our methodology. The considerations and opportunities were developed based on research, subject matter expertise, and stakeholder input. We developed recommendations based on all of the inputs received throughout the process. Recommendations were presented as "immediate," "short term," and "long term," as appropriate and indicated where recommendations are for consideration across the system or for facility specific consideration.



Redesign Elements

Redesign begins with an assessment of the care, treatment, and support needs of the populations, which helps to shape and define program needs. Once the program needs are identified, operational, physical plant, and infrastructure needs may be identified accordingly. Results of the needs assessment can then be converted in a formal work plan that includes action steps and timelines. Some plan elements and action items may be implemented immediately, while others depend on a prior plan element's execution. In addition, some plan elements encompass more than one population served and more than one facility.

Step 1 – Assess Population Needs (Level of Care)

The level of care required for individuals currently residing in the three adult facilities varies by sub-population. The plan must begin with a standardized assessment performed at each facility to determine patient level of care and resource needs. This assessment follows the identification of patients at each facility, prepared by each facility's medical director, who may no longer meet the level of care or admissions criteria for either ICF/IDD or inpatient psychiatric services. There are several possible assessment instruments available for use. For example, DHHS currently utilizes the interRAI Home Care tool for assessing level of dependency of individuals who may require nursing facility services. Similarly, the Level of Care Utilization System is an assessment created by the American Association of Community Psychiatrists that is clinically validated and combines clinical needs with levels of care, for use in resource management.⁴ Nursing facility level of care is a measure of dependency, and individuals who require a certain level of care can be served in a variety of institutional and community-based settings. Individuals who are older and may meet the criteria should be assessed using the interRAI Home Care tool before any assumption is made as to whether or not they qualify for a nursing facility level of care. BSDC has already performed nursing facility level of care assessments on the 25 residents for whom an "exception to retain" has been filed with the state survey agency, and all have been determined to have overriding medical needs that now meet established criteria.

Step 2 – Assess Structural Capacity and Licensing Requirements

After determining the scope of services needed and the number of individuals who would benefit from a change in setting during step 1, the second step would be to conduct a physical facility evaluation to assess additional opportunities for use. Facility administrative staff along with staff from the state survey and licensing agency should conduct an informal, walk-through evaluation of the current conditions of each of the buildings and structures, both in use and vacant. The evaluation should

⁴ <https://sites.google.com/view/aacp123/resources/locus>.



prioritize buildings/structures that actively support residents and staff, and should document needed repairs and maintenance for both short- and long-term planning. For unoccupied buildings/structures, the evaluation should classify each in terms of current and potential functionality and need for repair/maintenance. The capacity assessment should evaluate buildings that can be readily adapted to meet additional needs with minimal cost and disruption, while also providing for efficient staffing and access to programming and activities.

DHHS should use the informal assessment to develop more detailed facility and service redesign plans, conduct building and maintenance planning, and establish campus budget and spending priorities. The results of the evaluation can be used to determine building capacity and space needed to support different licensures and to repurpose buildings for internal and community uses. As this step requires the longest implementation time and related expenses, it should be completed early in the process as it will likely serve as a limiting factor when making other program changes.

Step 3 – Redesign or Develop Programs to Meet Population Needs

An expansion of facility capacity within the state-owned facilities is, however, only one of several steps needed to meet the growing needs of the older adult population, particularly those who are aging but also have significant behavioral or mental health conditions. There is also significant capacity required of available community-based programs and services to which to refer aging patients who may be suitable for inpatient discharge. The limited amount of community-based services is unto itself a critical hurdle that is out of scope for a facility redesign. The development and integration of community services specifically for older persons with significant behavioral health or psychiatric conditions has the potential to minimize service access issues and support positive outcomes for safe and healthy aging in place. An aging individual with significant medical, psychiatric, and/or behavioral health needs is more likely to use and benefit from services if there is a clear pathway that makes the delivery of services administratively simple, collaborative, and in the best interest of the individual receiving the services.

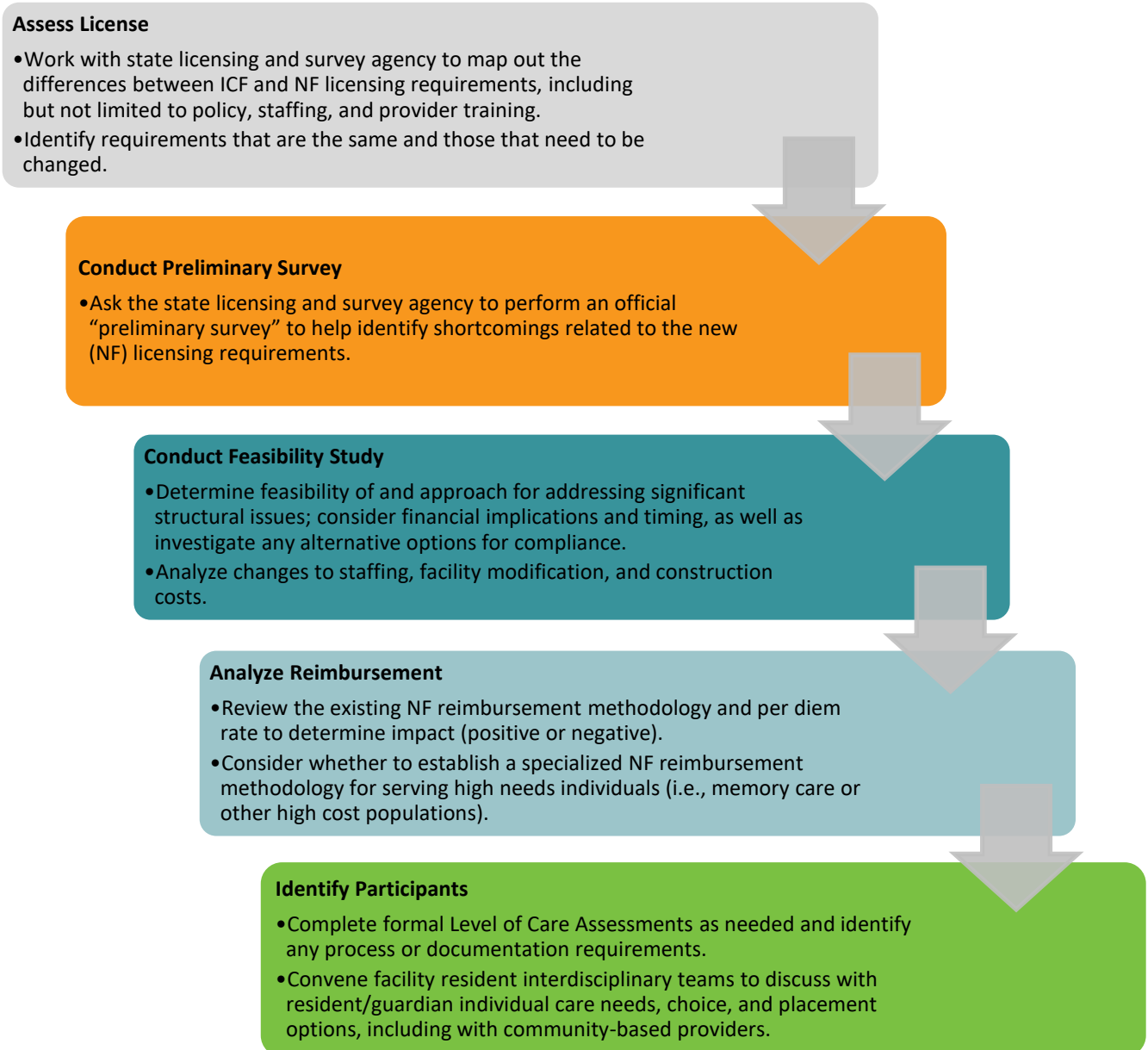
Step 4 – Develop Administrative and Operational/Facility Resources to Support Program Needs

There is a group of individuals currently residing at the state operated facilities, in addition to others not yet admitted, who will likely require long-term care at a state facility. To meet their needs, DHHS is considering the viability of creating a skilled nursing unit on the BSDC campus. It is generally allowable to license different parts of the same facility with different licenses. The State must specify which part of the facility (i.e. different floor, different wing, different cottage/building) has which license. In order to properly assess and resolve any issues with the transition of an occupied ICF/IDD bed to an NF bed there will need to be coordination with the state survey team. Myers and Stauffer examined this alternative,



and detailed activities to be undertaken to pursue this programmatic change. A summary of the steps is included in *Figure 2* below.

Figure 2. Facility Change Process





System of Care for Older Adults

In 2019, 16.2 percent of Nebraska’s population was over the age of 65 and this percentage is expected to increase over time. Similar to most states, Nebraska’s public system of care for older adults is challenged due to the growing segment of older adults and the distinct care needs of subpopulations, including those with a history of SMI or neurocognitive disorders such as dementia and Alzheimer’s disease. As the needs of the community have changed, DHHS has fulfilled the role as a safety net for individuals for whom alternative settings have not been feasible (i.e., safe, cost-effective, or have willing providers). As such, DHHS needs a comprehensive approach and long-term plan for addressing the care needs of older adults with complex conditions; consideration for the placement and treatment of aging Nebraskans with co-occurring medical, behavioral, and/or SMI will be an ongoing issue for the state system.

At all three facilities, the AFCA report found several instances where it was challenging to meet the needs of predominantly aging patients who may no longer meet active treatment requirements for either inpatient psychiatric or ICF/IDD care, but for whom community placements have not been possible or are not available. Below are highlights of the findings from the AFCA:

- *An aging IDD patient population raises regulatory compliance concerns with respect to the point at which their medical needs begin to override their ability and desire to participate in active treatment⁵ (habilitation) services. Currently BSDC has filed with the state survey agency an “exception to retain” for 25 individuals who are of advanced age and may no longer benefit from active treatment services but for whom alternative placement in the community or a nursing facility is not available.*
- *There are older adults served in the psychiatric hospitals whose conditions are complicated by age-related health issues and who need structured care.*
- *There is a significant gap in community placement for LRC patients, especially for sex offenders and individuals in the general psychiatric program who require long-term care.*

DHHS has completed initial assessments that have already identified a number of individuals who may meet nursing facility level of care. Additionally, DHHS continues to work to shape services and supports already offered within the facility to meet the needs of this population within the current setting. The

⁵ CMS defines active treatment as, “a continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping the enrollee function with as much self-determination and independence as possible.” CMS ICF/IID webpage.



following recommendations are designed to move the informal support system that exists into a formal system of support for older adults.

This approach is not without challenges. While the population continues to age, facilities designed for adults have not grown uniformly to serve all populations. For example, while nursing facilities have adapted to offer memory care for individuals with dementia, they have not made similar adjustments to accommodate people with SMI or with IDD. This has left a gap in system of care for older adults. These recommendations reflect an innovative solution to cover part of that gap. However, innovative as this solution is, there are very few completed examples to use as a model approach. DHHS will need to work together to find the best implementation approach for their own system of care. This recommendation requires a re-thinking of how these systems work and interact with each other and with the program participants.

It is important to note, that we are not recommending that people who are older but who have minimal health care concerns and who are able and willing to participate in active rehabilitative or psychiatric treatment be transferred to a nursing facility. Rather, the recommendation asks DHHS to think about the populations slightly differently so as to offer additional options for care for those individuals who need it. The table below describes at a high level population characteristics and needs.

Table 1. Population and Service Needs

Population and Service Needs		
IDD System	Behavioral Health System	Service Need
Older Adults with an IDD who have significant age-related health care needs.	Older Adults with SMI who have significant age-related health care needs.	Health care supports that also accommodate different cognitive levels and behavioral needs.
Older Adults with an IDD who have minimal age-related health care needs, but who need structure and assistance with behaviors and skills to live in the community.	Older adults with SMI who have minimal age-related health care needs, but who need structure and assistance with behaviors and skills to live in the community.	Treatment that stabilizes behaviors and provides skills to live independently in the community along with ongoing community supports.
Individuals with an IDD who typically live in the community, but who are having escalating behavioral issues and needs short-term stabilization.	Individuals with an SMI who typically live in the community, but who are having a serious psychiatric episode and who need short-term stabilization.	Short-term intensive treatment and stabilization with discharge back into the community with supportive services as needed.



This approach asks DHHS to look at the participants first as older adults to determine what services within the older adult system can meet some of these needs as it is currently structured and which systems would need to be adapted. For example, there may be supportive community-based services in the Aged and Disabled waiver that could provide the critical community-based supports for adults with and IDD or SMI. Those supports may need to be offered through a provider who has additional behavioral or medication management training to accommodate their additional needs, but the service system for older adults has supportive services already in place that could be used to provide more appropriate support. One of the hurdles for implementation will be in communicating to providers and discharge planning staff the ways in which the current system for older adults can be adapted to accommodate the needs of these populations.

Develop an Assessment Process for Older Adults that Spans All Available Service Needs Regardless of Current Placement

DHHS should develop policies and procedures that reflect the system of care already in place for older adults. These systems should be considered as part of the system of care open to any who meet the age requirements. Just as the system works currently for all older adults seeking services outside of the behavioral health and IDD system of care, these individuals should be assessed for any supportive services available through the older adult system supported by the Aged and Disabled waiver and the services funded by the Older Americans Act. Many of these community-based supportive services, assisted living services, or even services available through a nursing facility placement should be considered when developing plan of care for all older adults.

Develop a Skilled Nursing Unit for Patients Who Cannot be Placed in the Community

DHHS should consider the developing or adapting of an existing facility into a skilled nursing unit. There is a group of individuals currently residing at the state operated facilities, in addition to others not yet admitted, who will likely require long-term care at a state facility. To meet their needs, DHHS is considering the viability of creating a skilled nursing unit on the BSDC campus. It is generally allowable to license different parts of the same facility with different licenses. The State must specify which part of the facility (i.e., different floor, different wing, different cottage/building) has which license. It may be complicated for the State to transition an occupied ICF/IDD bed to an NF bed so there will be a need to coordinate transition issues with a state survey team. Myers and Stauffer examined this alternative, and detailed activities to be undertaken to pursue this programmatic change.

Look to Develop Existing Community Capacity and Partnerships

DHHS should look to strengthen existing community partnerships to develop greater capacity. Addressing discharge barriers should be a high priority. Once each older adult patient has been assessed, the patient's social worker should review and revise the individual care plan as appropriate.



Based on the assessment results and updated discharge plans, each facility should identify those patients who have “discharge barriers,” and itemize the nature of the barriers; i.e., whether they are patient-specific and/or external, such as uncontrolled behavior or family opposition to community-based placements. Initially, facility staff should conduct discharge barrier review meetings every other week during which the patient’s social worker updates the clinical leadership of the facility, including the facility director, about progress made towards obtaining discharge. Social work staff should be responsible for actively seeking community-based placements for individuals deemed appropriate for a community discharge, to include outreach and messaging.

Rethink Communications to Community-Based Providers

DHHS should examine and rethink current outreach efforts to community providers and consider making changes to the messaging. Possible changes may include greater collaboration with the state licensing agency as well as with staff completing discharge plans to emphasize to community providers that it is discriminatory to not accept a patient who meets their program admissions criteria simply because of their diagnosis (IDD or SMI), current placement location (e.g., ICF, state psychiatric facility, prison) or criminal history (they may have been cleared by the Court for community release).⁶

Given these challenges, it is practical to first invest time and resources in the assessment and “discharge barrier” tracking and community placement initiatives and evaluate results prior to moving populations from one regional center campus to another or creating new licensed programs such as a skilled nursing facility. It is critical that every effort should be applied (and documented) to place these patients in appropriate, alternative community long-term care facilities or other programs. To the extent that such programs and services are not feasible, DHHS must consider how best to create a community-based mental health and health care service delivery system that fills in the gaps. State policies and administrative structures should be written to wrap the appropriate services around the individual, rather than to sustain systems that require the individuals in need to seek separate, discreet services in separate administrative structures.

Implementation Considerations

Mirroring the steps in our overall process, the first step would be to assess the population to determine the number of people who may benefit from these recommendations. Similarly, processes should be updated to reflect a focus on assessing older adult programs as part of the initial process for service plan development or discharge planning. Transitioning the facilities will be a much longer process that is likely to take a substantial amount of time, but the strengthening of the existing community-based

⁶ Of note, social workers in New York City jails utilize this messaging approach to help place aging, medically complex patients who need a community-based long-term care placement.



services to accommodate these older adults can begin early on and continue as the facility work continues. The table below identifies some general tasks and timeframes.

Table 2. Older Adults Implementation Tasks

Older Adults Implementation Tasks			
Short Term	Medium Term	Long Term	Post-Implementation
Develop assessment process for older adults with an IDD or SMI.	Work with referral agencies and staff to implement and understand differences in assessment and services for older adults.	Continue to refine assessment, care planning, and discharge practices.	Monitor community and population needs for future planning.
Begin introducing and preparing providers to support older adults with additional needs.	Develop a pilot program or small group of providers who are willing to undergo additional training/coaching to serve these populations.	Provide ongoing support and expand to additional providers.	Continue to provide additional support to maintain stable placements.
Assess facilities for changes needed for different licensure.	Develop budget and planning needed for facility changes.	Implement facility and licensure changes as well as any Medicaid state plan changes.	Monitor community and population needs for future planning.

These recommendations require a combined approach and coordination among all of DHHS that supports the system of care for intellectual disabilities, behavioral health, and older adults. The tasks are many and overlapping and would likely require at least one dedicated resource to coordinate the plan goals and track outcomes.



System of Care for Forensic Patients

Redesigning forensic services provided at LRC is complicated by the need for involvement, and change, from the state’s judicial system and, to a certain extent, law enforcement. Reducing and managing the forensic waitlist will require stakeholders working in collaboration from different state systems; it cannot be decreased solely through action steps taken by DHHS. DHHS recently received funding from the legislature (LB1008) to develop outpatient restoration and evaluation services for individuals with pending criminal charges. This is a best practice and represents a significant step towards developing a full continuum of care for these individuals; however, further funding will be needed to establish a sustainable outpatient restoration program that can meet the service demand.⁷

The use of outpatient competency evaluation and restoration services is an evidence-based alternative that can reduce forensic service waitlists. As of 2018, 35 states have outpatient competency restoration services that offer an alternative to inpatient restoration programs, and at least 16 of these states have a formal competency restoration program located outside of an institution or facility setting (Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Louisiana, Nevada, Ohio, Oregon, Tennessee, Texas, Virginia, , Washington DC, Wisconsin [Wik, 2018]).⁸

Beyond the use of outpatient competency services, additional actions may be taken to reduce the waiting list of individuals committed to DHHS for restoration or evaluation, including the expansion of jail-based restoration.

Assess the Treatment Needs of Individuals Ordered to be Restored to Competency

DHHS should move towards the practice of hospitalizing only those individuals ordered for restoration who have medical necessity. A “snapshot” review/screen of each individual waiting in jail should be completed to determine if they could be restored in the community, in jail, or require hospitalization due to psychiatric treatment needs. Some individuals may not be eligible for outpatient restoration due to the nature of their charges and possible public safety risk. These people should be prioritized for competency restoration in a secure, facility-based environment, and LRC should continue to provide competency and evaluation services to this population.

⁷ The funding amount for outpatient forensic services in fiscal year 2020–21 was \$211,073. LB1008.pdf (nebraskalegisature.gov).

⁸ Wik, A. 2018. Alternatives to Inpatient Competency Restoration Programs: Community-Based Competency Restoration Programs. https://www.nri-inc.org/media/1508/ocr_website-format_oct2018.pdf.



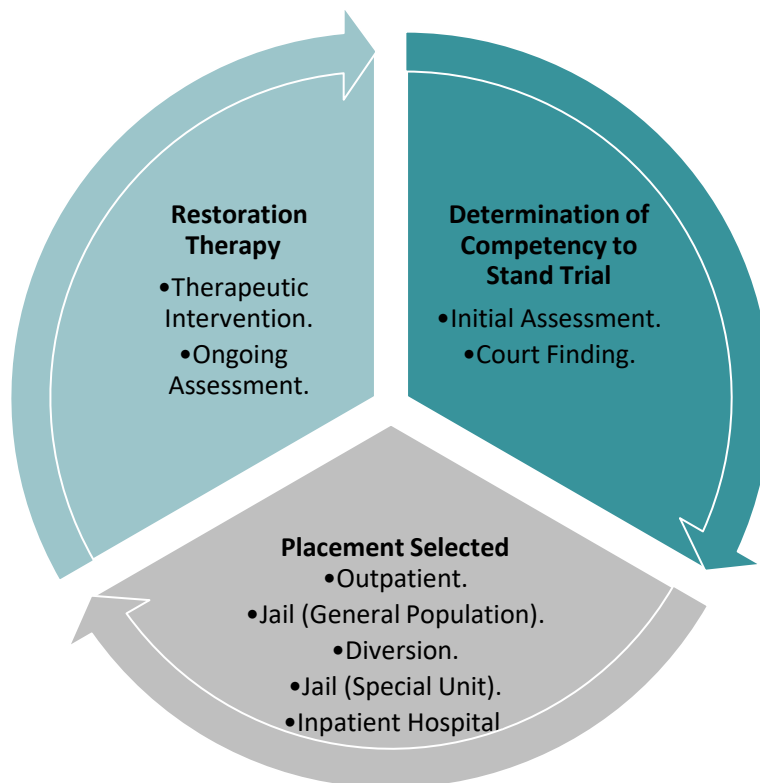
Assess Facility Structural Capacity and Licensing Requirements

In this step it is critical to assess the structural capacity of the system both internally and externally to DHHS. Implementing a more comprehensive forensic program would involve DHHS facilities, as well as jails, the court system, and community-based placements. There are different authorities that have control over different parts of the service system and facilities. Jails for example are not regulated health care facilities, but clinics within jails contain licensed health care professionals and equipment. Furthermore, the capacity of the jail system, court system, and community to provide for forensic exams and restoration outside of the state facility may not be uniform across the state, and likely some communities may be set up to expand and adapt while others will have limited capacity. Determining the full scope of constraints and structural limitations will be an important first step in understanding the landscape.

Redesign or Develop Forensic Programs to Meet Population Needs

Figure 3 below outlines the conceptualization of a continuum of services, essentially matching the restoration needs of the individual to an appropriate intensity of treatment rather than transferring all restoration individuals to an inpatient forensic hospital.

Figure 3. Continuum of Forensic Services





Continue the Development of Jail-based Restoration

The level of care review will help DHHS determine how many beds might be needed to provide jail-based restoration. The basic criteria for jail-based restoration are: compliance with psychiatric medications and no behavioral issues that might require seclusion or restraint. Many states and counties have developed jail-based restoration programs for this population, and these programs are successfully restoring individuals to competency. One opportunity to expand the use of these services may be to contract with community providers or state/county staff to operate a “host” county jail or detention center designated to house the program. DHHS should review the current restoration statute to determine if any revision is needed to allow additional flexibility in jail-based restoration and then proceed accordingly.

Conduct an In-depth, Focused Review of Forensic Services at LRC

Given the waitlist and pressure to reduce the list and admit forensic patients, LRC should arrange to conduct an independent review of its restoration program. This review should examine in detail the work processes from the receipt of the restoration order to discharge back to jail to identify if there are efficiencies to reduce the average number of days a person is in the restoration system. The review should examine the restoration curriculum being provided, and how a restoration patient spends their time at LRC. The purpose of the review is to identify opportunities to remove “waste” from the current process and drive down the average and median length of stay for pre-adjudicated forensic patients. The availability of trained staff should also be considered along with an examination of the points at which more or less staff or community partners may be needed to avoid bottlenecks.

Work with the State Court Administrator to Improve Restoration Process

It is important that the courts understand the urgency and importance of attending immediately to the needs of individuals in county jails that require restoration. Here, it is worth noting that approximately two-thirds of all people in jail are awaiting court action and are not yet adjudicated.⁹ Many states have experienced challenges with the number of days individuals spend in jail prior to the initiation of restoration services. One problem is that courts and county sheriffs may delay the transfer of individuals to and from the state hospital or designated restoration location due to resource constraints, such as staffing levels and transportation requirements. Some localities have addressed transportation barriers by hiring off-duty and/or former law enforcement officers to collectively serve as a fleet of on-call drivers. As noted above, these issues speak to challenges that DHHS alone cannot remediate and will require a cross-system solution. However, DHHS can and should be a thought leader and is the proper

⁹ Zeng, Z and Minton, T. 2021. Jail Inmates in 2019. Washington DC: Bureau of Justice Statistics. Accessed from Jail Inmates in 2019 (ojp.gov).



entity to educate courts about the restoration process and lead the development of cross-collaboration partnerships.

Establish Standards for Forensic Evaluators

DHHS should establish, in rule, standards and assessments for forensic evaluators and use these standards to review their performance. Establishing clear standards for forensic evaluations will also allow for greater growth and expansion of evaluators outside of DHHS so long as they adhere to the established standards. These standards can help the forensic system to grow without sacrificing consistency and standards of care.

Establish a Forensic Data Reporting System

Data should be collected and reported to management daily about the waitlist and the status of individuals on the wait list. Data elements should include the median and average length of stay for forensic patients and corresponding legal status. LRC leadership should closely monitor these reports to determine if system and operational changes positively impact the forensic census by reducing the waitlist and the average number of days individuals spend waiting for admission.

Implementation Considerations

Implementing the plan elements will require some changes to the administrative and operational structure of LRC and possibly DBH to support the expanding forensic services and improve the efficiency and effectiveness of the forensic program at LRC. Here is a list of potential changes and additional resources:

- *DHHS should assign staff to manage and expedite the transfer of the individual from the county jail to LRC and back to the county jail once a restoration report is filed with the court. This will reduce the number of days and corresponding administrative expense of individuals spent waiting either before or after restoration at LRC.*
- *Creation of a restoration unit for male patients at LRC, separate from patients found not guilty by reason of insanity or who require a competency evaluation, would serve to focus the therapeutic environment on restoration and reduce the average length of stay for restoration patients. Patients who are not working toward restoration typically have very different therapeutic needs and creating separate environments will allow staff to tailor the milieu to the needs of the different populations.*
- *Evaluate if non-clinical staff are needed to manage the forensics services program, including outpatient restoration, jail-based restoration, and transfers of restoration patients to and from LRC; recruit and hire for necessary positions.*



-
- *Recruit and hire a licensed neuropsychologist or forensic psychiatrist who can provide testing and assessment of forensic patients at LRC. This position must be separate from treatment staff on the LRC forensic unit to avoid conflict of interest.*
 - *Monitor the forensic census, as the state forensic continuum continues to develop to determine if the number of forensic beds at LRC may be reduced.*



System of Care for Sex Offenders

The sex offender program operates across multiple agencies. Managing the needs of the population to ensure that the services are coordinated and best practices are implemented consistently is paramount to recovery, as well as ensuring that resources are efficiently used. Additionally, ensuring that patients are properly assessed, appropriately transitioned through the system, and have access to services that meet the level of need will help DHHS in targeting resource use. A comprehensive examination of the variance in levels of care among sex offenders with different needs can help inform development of an optimal sex offender treatment program that spans both NRC and LRC.

Leverage the Risk-Needs-Responsivity Model for Sex Offender Patients

Nebraska has adapted the principles of the risk-need-responsivity (RNR) model to its patients (Andrews & Bonta, 2010). The RNR model is considered to be one of the most influential models for the assessment and treatment of offenders. It was originally developed for use with criminal justice populations but it can also be applied to treatment, which is considered to be a best practice. The risk principle states that the intervention, treatment, supervision, etc. should match the level of risk posed by the individual and could include more contact hours or differing treatment intensity for those deemed of greater risk. The need principle is that treatment and intervention should target the criminogenic and non-criminogenic needs of the individual.¹⁰ Finally, the responsivity principle addresses the interactions between the individual and treatment, and stresses that the treatment should be delivered in a culturally appropriate way for a given individual (see Yates, 2013 for more information).¹¹

DHHS should leverage RNR assessments to determine the program needs of the patients being served and plan forward to strengthen the system of care.

Assess Facility Structural Capacity and Licensing Requirements

After determining the scope of services needed, the second step would be to conduct a physical facility evaluation to assess additional opportunities for use. DHHS should use the informal assessment to develop more detailed facility and service redesign plans, conduct building and maintenance planning, and establish campus budget and spending priorities. The results of the evaluation can be used to determine building capacity and space to support different licensures/certifications and repurpose buildings for internal and community uses. As this step requires the longest implementation time and the greatest level of capital funding, it should be completed early in the process so that it can be

¹⁰ Criminogenic needs are things such as lifestyle, personality characteristics, or histories of rule violations. Non-criminogenic needs include things like self-esteem, victim empathy, and denial.

¹¹ Yates, P. 2013. Treatment of Sexual Offenders: Research, Best Practices, and Emerging Models. International Journal of Behavioral Consultation and Therapy. 8(3-4): 89-95. EJ1017917.pdf (ed.gov).



considered when making other program changes. As this is a program targeted to a very specific population, DHHS should consider which type of license or certification best achieves the program needs. It may differ from the license or certification utilized by other facilities.

Redesign or Develop Programs to Meet Population Needs

After formally assessing the levels of care for patients in the sex offender program and establishing their resource and support needs, the next important step to evaluate the treatment program is to identify opportunities for alignment between LRC and NRC licensing and program requirements. Improved alignment will support the continuity and quality of care for patients by streamlining administrative processes, facilitating the transfer of patients between hospitals, and improving care and service delivery.

Evaluate the Discharge Process from NRC To LRC, as well as to Community Providers

DHHS should critically evaluate discharge readiness from NRC to LRC and the transition process. The discharge process should be a warm hand-off, which means that discharge discussion occurs in front of and informed by the patient. During stakeholder engagement, staff from NRC reported that staff at LRC did not always understand the needs or behavioral challenges of a patient, which created barriers to delivering patient care. Likewise, community providers noted that they often receive patients from NRC and LRC with insufficient information to determine the care and supports needed upon admittance.

Continue to Share Delivery of the Sex Offender Program Across LRC and NRC

NRC has a total of 120 beds, 95 of which are allocated for the sex offender program, and LRC has 217 beds, with 81 designated for the sex offender program. Due to the significant size of the sex offender patient population, DHHS should continue to offer the sex offender program in its current, phased approach in which Phase 1 is at NRC, and Phases 2 and 3 are at LRC. This is a successful model, especially as LRC has more community options available for resident outings and work assignments that support treatment and rehabilitation. Although the current patient population of sex offenders could be housed at LRC, a significant change in approach would require a disruption to the facility, its patients, and staff. This would also significantly and negatively impact the number of beds available for general psych and forensic patients at LRC.

Critically Evaluate the Use of Evidence-Based Practices and Programs that are used in the Existing Sex Offender Program

In the AFCA report, NRC and LRC staff state that they follow evidence-based treatment practices. A motivational interviewing initiative is underway across the facilities. However, stakeholders at LRC report that evidence-based treatment activities vary in use and consistency due to staffing shortages and leadership changes. Ensuring the continued use of evidence-based practices is important for patient care, recovery, and success. Sustained practices can be accomplished with leadership focus and direct initiatives, like the motivational interviewing initiative. Evidence-based practices can also be supported



through staff training and education and integrated standard operating procedures that align with evidence-based practices.

Develop Administrative and Operational/Facility Resources to Support Program Needs

To maximize care coordination and minimize staff burnout, Myers and Stauffer recommends the following steps to improve delivery of the sex offender treatment program across both LRC and NRC facilities. These steps require minimal disruption to the patient population and no significant changes to facility infrastructure or building use.

Align Sex Offender Treatment Programmatic Features and Policies Across LRC and NRC

In collaboration or coordination with community-based providers, NRC and LRC should develop a universal behavioral health discharge form that transmits critical client information needed to admitting facilities and providers to ensure the availability of proper supports upon admittance, thereby reducing recidivism. The LRC Community Services Providers Workgroup developed specific data points to similarly support discharges. DHHS should leverage that effort to update and combine existing discharge documentation to align its programs, practices, and policies to further support the continuum of care and improve staff communications, hiring, and retention. Although some elements are already aligned, the two programs should share a similar framework to the greatest extent possible.

Invest in a Data Collection System that can be used Across the Sex Offender Program.

Because the sex offender program is operated across the two facilities, a central data system that is usable by both LRC and NRC is imperative to care coordination for this population. Current stakeholders report challenges caused by different and incongruent data collection systems. One area this impacts is the ability to calculate accurate length of stay data, information that is important to assessing patient needs and providing patient care.

Implementation Considerations

Implementing the plan elements will require administrative and operational coordination across NRC and LRC, and with community-based providers. The facility sex offender program is a good model; however, the opportunity to expand services and better support exiting patients will require that DHHS and DBH work to expand opportunities for patients to transition into the community. Following is a list of recommendations and additional resources:

- *NRC and LRC leadership should work together to assess the program needs based on existing patient assessments to determine whether there are opportunities to improve or evolve programming.*



-
- *DHHS corporate and divisional leadership will need to work to ensure that evidence-based practices are implemented and followed consistently across the two facilities. This may include hiring additional staff, staff training, or program monitoring.*
 - *Facility leadership will need to continue to engage community-based providers to support ongoing development of transition and discharge options.*
 - *NRC and LRC leadership should leverage the LRC Community Services Providers Workgroup to develop a universal behavioral health discharge form that transmits information about clients that admitting facilities and providers need to ensure proper supports are available upon admittance.*



Summary

This Adult Facility Redesign Report draws on all of the information obtained during the development of the AFCA. It prioritizes resident and patient needs as a basis for making any recommendations regarding program, physical infrastructure, administration, or staffing elements. This redesign report looks across the system to provide appropriate care supported by strategic resources. As stated in the AFCA Report, opportunities to redesign the system depend on DHHS ability to build on current work and past success. This redesign report is only one part of that effort that DHHS has already begun.