IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

UNITED STATES OF AMERICA,	)	
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Plaintiff,	)	
	)	
v.	)	8:08-CV-271 (RGK)
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THE STATE OF NEBRASKA, *et al.*,	)	
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Defendants.	)	
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MEMORANDUM IN SUPPORT OF THE PARTIES' JOINT MOTION TO DISMISS

For the reasons set forth below, the parties jointly move the Court to dismiss this case with prejudice given the State's sustained compliance with the terms of the remedial Settlement Agreement in this case. This memorandum outlines a success story, where the State has implemented reforms that have transformed its service-delivery system for people with developmental disabilities ("DD"), greatly expanded/enhanced community capacity, minimized reliance on institutional services, and generally improved outcomes for people with DD.

I. BACKGROUND AND PROCEDURAL HISTORY

A. Notice of Investigation, Investigation, Findings Letter

On May 29, 2007, the United States notified then-Governor Dave Heineman, that it would be investigating the State's largest DD institution – the Beatrice State Developmental Center ("BSDC"). From October 15-19, 2007, the United States conducted an onsite review of BSDC with a team of expert consultants. Through BSDC, the State also operated "Bridges" – an isolated, highly-secure, and restricted residential facility – on a separate campus. The United States conducted an onsite review at Bridges contemporaneous with the visit to BSDC. BSDC and Bridges were the only State-run institutions for persons with DD in Nebraska.

A primary focus of the investigation was determining whether the State was complying with the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134 (Part A), as interpreted in *Olmstead v. L.C.*, 527 U.S. 581 (1999), requiring that individuals with disabilities receive services and supports in the most integrated setting appropriate to their needs.

On March 7, 2008, the United States issued findings detailing systemic conditions and practices that it found violated the constitutional and statutory rights of individuals with DD in the State's system. The United States found that: BSDC and Bridges residents frequently experienced abuse, neglect, harmful restraints, and avoidable serious injuries; residents' serious behaviors were inadequately addressed; residents' health care needs were often unmet; and residents did not receive services in the most integrated setting as required by the ADA and *Olmstead*, with significant barriers to community placement.

B. Court-Ordered Settlement Agreement

Shortly after the United States issued its findings, the parties reached agreement on a remedial consent decree, entitled "Settlement Agreement," which was filed with the Court on June 30, 2008. On July 2, 2008, the Court entered the Agreement as an order of the Court.

The Agreement addressed all of the deficient areas set forth in the United States' findings letter. It required the State to remedy health, safety, and welfare issues at BSDC and Bridges, and to significantly expand and enhance community capacity to ensure positive individual outcomes in integrated settings. The Agreement emphasized the need to transition institutionalized people to the community.

The Agreement specified a soft target of four years for Nebraska to fully implement all requirements, but specified that the Court was to retain jurisdiction until the State implemented all Agreement provisions and maintained implementation for one year.

C. Scope of the Impact of the Settlement Agreement

The Agreement's target population includes anyone who resides or resided at BSDC or Bridges on or after the United States' onsite investigation in October 2007, a total of 353 people.[1] However, the overall impact of the Agreement was not limited to this group. The Agreement addresses both community services and reforms in the institutions. Early on, the parties agreed that the State would not create a bifurcated DD system, where reforms and enhanced community capacity would only reach those hundreds who were or had been institutionalized. Instead, the State agreed to expand community services to benefit everyone in its DD system, regardless of whether they had ever lived at a State-run institution. As a result, the reach of the Agreement has extended far beyond the institutions, and instead, has positively impacted the almost 5,000 individuals served by community providers throughout Nebraska.

D. Independent Court Monitor

The Agreement provides for independent oversight and compliance reporting by a court monitor, called the "Independent Expert." Maria E. Laurence has served in this role since December 2009. Ms. Laurence, along with a team of experts, has conducted regular, in-depth reviews of the State's DD system, including onsite reviews at BSDC, Bridges, and various community sites. On December 3, 2014, Ms. Laurence issued her latest compliance report (hereinafter "IE Rep."), which is attached as Appendix A to the parties' index of evidentiary materials, filed contemporaneously with the instant motion and supporting memorandum. All "Appendix" designations in this memorandum refer to attachments to the accompanying index of evidentiary materials.

[1] On the last day of the investigation, there were 325 residents at BSDC and 12 residents at Bridges. Since then, the State admitted 12 more people to BSDC and four people to Bridges.

II. INTEGRATED COMMUNITY SERVICES

A. Placement/Services in the Most Integrated Setting

The principal requirement regarding community services is that people with DD are to be "served in the most integrated setting appropriate to meet each person's individualized needs." Agreement ¶ III.B.23. The State agreed that "*all* residents of BSDC meet the essential eligibility requirements for placement and habilitation in integrated community settings." *Id.* ¶ III.B.24 (emphasis added). More particularly, the Agreement requires the State to:

- provide individuals with adequate and appropriate protections, supports, and services in the community to meet their individualized needs; and
- implement an effective community monitoring system to ensure individuals are provided with the protections, supports, and services they need to succeed in the community.

Id. ¶¶ III.B.25-42, 48-53.

The Agreement requires the State to place individuals into smaller community homes and to avoid placing individuals into nursing homes or other institutional settings, recognizing that nursing homes are "not well-suited" to meet the needs of persons with DD. *Id.* ¶¶ III.B.34-35.

The Agreement requires Nebraska to expand community capacity to better serve people, especially those with complex issues. *Id.* ¶¶ III.B.43-44. It stresses the need to "avoid crises marked by the escalation of health care and/or behavior problems, and to minimize or eliminate failed or troubled community placements due to poorly addressed resident behaviors and, thus, minimize or eliminate re-institutionalization." *Id.* ¶ III.B.44. It requires an expanded community outreach program to address unmet needs that place people at risk of institutionalization; the program is to "keep individuals as independent as possible, and in familiar surroundings in their homes in the community, and away from more restrictive placements such as hospitals, nursing homes, psychiatric facilities, and institutions." *Id.* ¶ III.B.46.

B. Minimized Reliance on Institutional Services and Decreased Institutional Census

1. Overall Decline in Institutional Numbers at BSDC and Bridges

In its 2007 findings letter, the United States concluded that the number of community placements from BSDC had been very low and had stagnated: in the previous decade, the State had never placed more than six residents in any year in the community and the overall BSDC census typically declined only as a result of deaths or transfers to other institutional settings.

Entry of the Agreement effectively "closed the front door" to State-run institutional DD services in Nebraska; the last admission to BSDC was on June 9, 2009. Since entry of the Agreement, the State has placed 148 individuals from BSDC and Bridges into integrated community settings – 42 percent of the total "institutional" sub-group of 353 people. As of July 21, 2015, there were only 116 residents still living at BSDC, a 64 percent reduction in the census from the time of the investigation.[2] As we discuss in greater detail below, by June 2013, the State placed all of the residents of the Bridges institution into community settings and then closed the institution altogether. As a result, there is now only one, greatly minimized, State-run DD institution left in Nebraska.[3] For a comparison that shows the declining DD population in State-run institutions with the increasing community DD population, see the graphs in Appendix B-1, attached to the accompanying index of evidentiary materials.

[2] Thirty-five BSDC residents have died over the past eight years.

[3] To make permanent the shrinking of BSDC, the State has taken the extraordinary step of physically demolishing at least three large buildings on campus.

Consistent with Agreement goals, the State continues to de-emphasize use of homes of four or more, preferring instead to serve people in smaller settings. Almost 4,000 of the 4,988 people served through community waivers[4] live in community homes of three or fewer people.

As was the case with admissions to BSDC, entry of the Agreement effectively shut the front door to other institutional settings, such as nursing homes or private DD institutions, for people in the sub-group.[5] There are only 16 individuals from the sub-group who are now living in other institutions. The last transfer to a private nursing home from BSDC occurred on December 22, 2009; the last transfer to a private institution was on May 11, 2010.

2. Closure of the Bridges Institution

In 2005, the State created the BSDC-affiliated Bridges institution to serve individuals with DD who posed significant risks to themselves or the community; nearly all of its residents had previous contact with law enforcement and/or the judicial system. Bridges was established as a locked, highly-restrictive institution akin to a forensic mental health facility. Although Bridges had close administrative ties with BSDC, it was physically located far from Beatrice, on the closed campus of a former mental health facility in a rural setting in central Nebraska.

While at Bridges, the residents were regularly subjected to a high number of restraints – including multi-point mechanical restraints, as well as physical and chemical restraints. The residents left campus only rarely and they were allowed outside for only an hour or two each day in a small fenced area that was smaller than the yard death-row inmates are provided at the state penitentiary. The Bridges residents frequently suffered injuries in confinement.

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[4] "Waiver" is a regulatory term describing the primary funding mechanism for community services and supports for people with DD.

[5] In addition to State-run BSDC, there are two private DD institutions in Nebraska, each housing a little over 100 individuals. Mosaic, a private non-profit organization, operates both facilities.

Prompted by the Agreement, the State developed a community re-location program for the Bridges residents. In 2011, the legislature approved $1.5 million to construct three four-bedroom homes in nearby Hastings that would enable them to live in integrated settings. In June 2013, the State moved all of the residents to the newly-constructed community homes and then closed the Bridges institution altogether.

Since the relocation process began in 2011: none of the individuals have had contact with a psychiatric hospital; the use of mechanical and programmatic physical restraints has been completely eliminated; emergency safety interventions are rarely needed; there are far fewer incidents and injuries; and the use of psychotropic medications has been significantly reduced.

Since moving out of the institution, the former Bridges residents have been participating fully in community life. All but two are involved in paid work in integrated community settings; community jobs include working at a restaurant, detailing cars, performing janitorial work and lawn maintenance, caring for pets/animals, and growing vegetables for sale. One man was hired recently over other candidates who did not have any disabilities.

In April 2014, the monitor and her team, along with the parties, visited the former Bridges residents in their new community homes. In her report, the monitor concluded:

- "In stark contrast to … the Bridges program, the new homes were lovely and the individuals living there appeared to be benefitting from the transition to residences that allowed for more opportunities to learn and practice more independent living skills."

- The transitions have "substantially increased their integration into the community, while being ever-cognizant of the need to do so safely."

- The homes highlighted the "positive results arising from the State's firm commitment, sustained advocacy, thoughtful planning, and careful allocation of resources."

- "Particularly within the confines of a state government structure, it was no easy feat to build these homes from the ground up, and put all of the necessary pieces in place to

> allow the men to move … All of the staff involved should be commended for their work on this project, as should the men who played an integral role in the process."

IE Rep. at 8, 71.

3. Transition Process from Institutional Settings

The State has taken effective steps to comply with the transition planning requirements of the Agreement in order to help reduce the institutional census and to ensure successful placement in the community. The State's program planning begins early and is premised on the notion that each person in an institution can live in the community with adequate services. Transition plans, in conjunction with the annual Individual Personal Plan ("IPP"), detail each person's needs and preferences and ensure that only community providers who can meet an individual's particular needs will be selected. The transition process is carefully organized and includes pre-transition visits to receiving community programs and close coordination with community providers.

The monitor concluded that the State's transition planning demonstrated "significant progress." *Id.* at 9. She reported that revised transition procedures have resulted in "much smoother transitions" for individuals, largely due to better information-sharing and better transition plans that "fairly comprehensively" identified individualized needs for protections, supports, and services. *Id.* at 9-10. She found that it was "clear that there was a commitment to provide prompt and effective support and intervention for individuals to ensure the success of their transition to the community for individuals moving from BSDC." *Id.* at 138-39.

Overall, the monitor found that the State has taken many steps to "increase community capacity, and improve its oversight of the community system to ensure that individuals the Settlement Agreement covers are provided the protections, supports, and services they require." *Id.* at 5. She reported that the State built "much-needed infrastructure for the community

system," which was important, as "[m]any of the pieces necessary for a healthy community system had either been missing or were not operating in a fashion necessary to meet the goals and the requirements of the Settlement Agreement." *Id.* She noted that "important changes" had been made to improve access to community services for people in need, "particularly individuals with complex medical and behavioral needs." *Id.*

The monitor concluded that reforms have produced positive outcomes for people, noting that many "spoke with gratitude" about the State's efforts to transition them to, and support them in, community settings. *Id.* at 6. She reported that the sister of a man transitioned to the community said: "Our family never thought his life would be this full." *Id.* at 7.

4. Promoting Community Placement

In its 2007 findings letter, the United States found that guardian opposition was a barrier to placement and concluded the State did little to promote placement once a guardian expressed reservations, even when teams concluded that residents could benefit from community living.

Since entry of the Agreement, the State has implemented effective measures to continually engage guardians about community alternatives even where opposition has been expressed. The State now repeatedly re-offers community-based alternatives to institutional care; this stands in stark contrast to the passive practice in place prior to the Agreement.

Due to the diligent efforts of its personnel, the State has succeeded in helping previously resistant guardians to consider, and then embrace, community transition, especially for people who had been living in nursing homes. Nebraska has also taken important steps in recent years to challenge some guardians who were negligent or not acting in the best interests of their wards. The State's actions in this regard directly resulted in a number of individuals being able to move from an institution to a community home.

The monitor concluded that the State had undertaken "significant efforts" to educate individuals and guardians about community alternatives. *Id.* at 67. She reported that "it was clear that [State personnel] were making regular contact with family members/guardians, and offering information regarding community options." *Id*. at 63. She found it "positive" that the State revised guidelines to prompt teams to "address actions that could be helpful in individuals and guardians learning more about community options that could meet their needs." *Id.*

C. Significantly Increased Community Capacity

In its findings letter, the United States concluded that Nebraska lacked sufficient capacity in the community, particularly for people with complex health or behavioral needs.

1. Continuous and Significant Budget Increases for Community DD Services

Since entry of the Agreement, the State has made a concerted and sustained effort to expand community DD services throughout Nebraska in order to ensure that adequate service capacity exists to meet outstanding needs. At the recommendation of the State's DD agency, the Governor consistently sought, and the legislature consistently provided, significant new funding to expand the scope and availability of community DD services. This funding allows the State to serve more people well, in integrated settings, than in congregate settings like BSDC.

Annual State expenditures on community DD services and supports basically doubled during the life of the Agreement – from $72.9 million to $145.5 million – representing an additional $72 million dollars per year for community-only initiatives than was available before entry of the Agreement. These are state-only dollars. In addition, Nebraska receives about a 50 percent federal match through the Medicaid program, so the overall increase in community funding is about twice the state-budgeted amount. For a table and graph showing annual community service budget amounts during the life of the Agreement, see Appendix B-2.

The increased spending in the community is cost-effective. In 2014, the average annual cost per person at the BSDC institution was $393,470; given the ever-declining BSDC census, this cost figure has increased markedly since 2007. By contrast, the 2014 average annual per person cost of services through the comprehensive community DD waiver was just over $58,000; this figure has decreased since 2007. *See* Appendix B-3. Thus, today, it costs about six times more on average to serve someone at BSDC than in the community on the comprehensive DD waiver. [6] This is a "win-win" situation where Nebraska is now serving more people in better, more integrated settings that comply with the ADA and *Olmstead* for less money on average per person than if the State had continued with or pursued more institutional alternatives.

In general, the increased funding has expanded community services, improved their quality, and provided more effective oversight of service-delivery. More specifically, the funding increases ensured that BSDC/Bridges residents could move to the community when they chose, increased reimbursement rates for community services to better meet individual needs, removed a significant number of people from the State's DD waitlist, helped ensure that high school graduates with DD receive day services, and enabled the State to implement its pilot ward permanency project to meet the needs of at-risk DD youth and to avoid institutionalization.

The additional community appropriations today make a positive impact in the lives of about 5,000 people with DD who need integrated services (4,988 on average in 2014). Since the United States' investigation, the number of people who are on the comprehensive DD waiver and also get residential services has increased by 45 percent (from 2,391 in 2007 to 3,472 today), and

[6] This is necessarily an estimate as the waiver cost does not include certain expenses for health care which are included in the cost figures for BSDC.

the number of people on (or about to be on) the day waiver has increased 31 percent (from 748 in 2007 to 979 today).

2. Revised Waiver Rate Methodology Implemented with Significant Additional Funding

An important aspect of expanding and enhancing capacity in the community is ensuring that rates within the waiver – the primary funding mechanism for community services for people with DD – are adequate to meet individual needs and preferences. This addresses immediate needs and better ensures sustainability going forward. On July 1, 2014, the State implemented a new rate methodology with the additional funding referenced above, that, for the first time, effectively provides those on the waiver with adequate services to meet individual needs. The monitor concluded this was a "substantial effort" to address outstanding issues. IE Rep. at 6.

The State also changed set amounts to individualized service budgets that now enhance flexibility and facilitate access to needed services and supports. In essence, individuals now get an individualized budget amount and can spend it flexibly on the services they need and prefer.

3. Community DD Waitlist

For the period July 1, 2009 through December 31, 2012, the State expanded funding to serve people with DD on the waitlist, enabling the State to offer DD services to 2,470 people on the waitlist, approximately 1,680 of whom accepted services. The State has also been taking more aggressive and expansive steps to identify people earlier, extend eligibility to more people, and add people to the waitlist before they need services.

4. Waiver Enhancements – Expanded Community Options and Improved Oversight

In 2011, the State revised its waivers to expand the services available to individuals in the community. The State included provisions to add flexibility, to add non-specialized services,

and to provide more person-centered practices to allow people with DD to work and participate in their communities as fully as possible.

In 2010, as part of an overall effort to centralize oversight, the State began to revise its fragmented regulatory structure to create a comprehensive set of community DD waiver regulations with more of a focus on outcomes; in doing so, it incorporated the input of stakeholders, emerging trends in service delivery, a focus on person-centered outcomes, as well as the requirements from the Agreement. While the regulations were under consideration, over four dozen national and international DD professionals praised them for embodying standards of care that would eliminate restraints and provide meaningful days. On July 16, 2011, the State issued its new regulations.

The monitor reported that the new regulations provide the State with a "wide array of actions to assist or compel providers to comply" with the regulations and to ensure that providers immediately address issues related to individuals' health and safety. *Id.* at 142.

During the current year, the State has worked on drafting regulatory changes to conform to the new home and community-based services rule from the Centers for Medicare and Medicaid Services ("CMS"), which imposes stricter requirements on jurisdictions with regard to what constitutes a community setting. On December 1, 2014, the State submitted its transition plan to CMS. In implementing the plan, the State commits to minimize or eliminate residential community settings serving four or more people, as well as sheltered workshop settings.

5. *Expanded Number of Community Providers*

To meet the terms of the Agreement and the increased demand for community DD services throughout Nebraska, the State has made significant efforts to expand DD provider capacity in the community. Community-based "specialized" providers deliver the majority of

community services to individuals with DD. Prior to 2009, there were 25 specialized providers certified in Nebraska. Since then, the State has certified an additional 35 such providers – well over a 100 percent increase – who operate a total of 87 certified community programs.

The State has also implemented measures to enhance "non-specialized" services and supports to promote better access to services and opportunities in the community, obtain or maintain employment in truly integrated community settings, assist individuals to develop self-advocacy skills, assist individuals to identify and sustain a personal support network in the community, and help with household activities necessary to maintain independence at home.

In her report, the monitor concluded that a sufficient "array of providers was available that had the capacity to provide housing and residential services to individuals with varied needs," that there was an "appropriate range of [community] alternatives" allowing providers to serve individuals with a "wide range of support needs," that "the range of community living alternatives appeared to continue to expand, offering a variety of available levels of support to match the needs of individuals," and that the homes she visited were "integrated into neighborhoods, providing the opportunity for individuals to be members of communities, as well as to participate in household activities." *Id.* at 66, 70, 71.

6. *Expanded Community Capacity to Address Complex Health Conditions*

To improve community capacity in health care to better meet individualized needs and to comply with the terms of the Agreement, Nebraska has taken a number of important steps.

a. New Accessible Community Homes

In March 2009, the State contracted with a provider to build and operate 11 community homes across Nebraska to serve dozens of people with both DD and complex health care issues; the State's community system previously lacked sufficient capacity to address such needs.

b. Health High-Risk Screening Tool

Since entry of the Agreement, the State has implemented a health high-risk screening tool with a prioritization matrix to identify individuals with DD in the community who have significant medical issues. This tool helps the community teams to identify areas of risk so that they can better address outstanding needs, obtain additional health services and supports, and/or obtain expert consultation.

In 2011, the State screened all individuals with DD in the community who were receiving State services and began screening all individuals who enter the State's DD system, as well as all individuals who experience a change in health status. After screening, the State disseminates to community providers information related to individuals' needs.

c. Traveling Clinical Review Team

In April 2012, the State created a community medical/clinical review team of two health professionals to assess at-risk individuals in the community to determine whether they were getting adequate health care. This team made onsite visits, reviewed services, made recommendations for modified treatment, and established a follow-up system to address the implementation of recommendations.

The team found that the majority of individuals in the community received appropriate primary health care, but that there were gaps and inconsistencies in illness prevention, early recognition practices, follow-up on laboratory testing, and timely referral to specialists. The team also found some training deficits. The team report called for enhanced training, standardization of health support practices and guidelines, allocation of funding for health support based on individualized needs, regular monitoring, and continuous quality improvement.

The team's mandate was originally the group of individuals placed from BSDC, but has expanded to include a larger group of people with DD in the community. Individuals are prioritized based on hospital contacts, other health outcome criteria, and the results of the health risk screens, with those with the highest risk scores addressed first.

The team provides consultation and technical assistance to community provider agencies to improve health care services. They generate written findings on medical, nursing, and clinical care, and recommend changes in care when necessary. Their reports address individual needs and help build awareness of critical systemic issues, unmet needs, and what actions should be taken to address these needs. The State's chief DD medical officer reviews all reports, ensuring that the system and leadership know the most pressing health care issues, as well as the people most at risk. The State sends the reports to the individuals' community teams. The team then follows up to determine if the teams have any questions or need additional technical assistance.

The monitor reviewed several team reports and found them to be "very comprehensive and individualized to meet each individual's specific health needs." *Id.* at 92. She confirmed the recommendations were tracked and implemented, and noted they often produced "positive outcomes." *Id.* She found that this process provided a "quality check" and that it expanded "community capacity for providing health care to individuals with complex medical needs." *Id.*

The monitor concluded that the knowledge and skill of the team professionals were "welcome additions" to the State's DD system and that State community personnel were "seeking and using their expertise." *Id.* at 95. She reported that the team provides a "resource" to assist State personnel and community providers implement systems to provide consistent and thorough health care oversight and that it was "evident" that the State's team had given community providers "significant assistance and information" that contributed to improved

outcomes. *Id.* at 81, 95. She concluded that continued use of the team will be "invaluable in ensuring appropriate health supports are provided" to those in need in the community. *Id.* at 95.

d. Specialized Training and Services for Physical and Nutritional Support Needs

For years, the State struggled to provide adequate physical and nutritional supports ("PNS") to individuals in the community; the monitor had called this a "significant concern." *Id.* at 13. By 2014, she reported that the State was starting to take "effective steps" to expand the capacity and expertise of community providers and clinicians through the planning and provision of PNS community-based training and clinical instruction. *Id.* at 83.

The monitor concluded that, although more needed to be done, the statewide PNS training will enhance the knowledge base of community providers and clinicians to better support individuals living in the community or preparing to move to the community. She described proposed PNS training initiatives as "impressive." *Id.* She concluded that the training "move[s] the State forward in expanding the capacity of community providers and clinicians in their knowledge of PNS and implementation of appropriate PNS plans for individuals." *Id.* at 85-86. She reported that although more work was needed, community providers had now begun to implement individual-specific procedures to provide direct care staff with written instructions in providing supports for people during mealtimes, bathing, transfers, medication administration, and oral care. *Id.*

e. Health Care Curriculum and Training for Community Providers

In 2012, the State developed a video-based health supports curriculum to help community staff meet the health care needs of people with DD in the State's system, especially those with complex conditions. The State has made the full curriculum available to all community providers in Nebraska at no cost. The training materials are comprehensive, specific for people

with DD, and easy to read for non-clinical staff. The State has provided training to over 260 community staff on how to identify and respond to individual health conditions and emergencies. The monitor concluded that the curriculum was a "valuable resource." *Id.* at 82.

f. Other Community Health Care Initiatives

The State is expanding a tele-health network for underserved areas. Community staff can access the network at many local hospitals and the regional public health clinics across Nebraska. The network is used mainly for psychiatry and neurology consultations.

7. Expanded Community Capacity to Address Complex Behavioral Conditions

a. Intensive Mobile Community Behavioral Services

In its findings letter, the United States reported that the State operated a limited community outreach program out of offices on the BSDC campus, to help keep people with behavior problems or mental health issues in the community and away from long-term institutionalization. The United States recognized that this mobile program played a positive role in helping to maintain community tenure, but also noted that the demonstrated capacity of the program was very small, helping only a couple dozen people per year across Nebraska.

The State gradually replaced the BSDC-based outreach program with six mobile behavioral consultation teams in the community – three in Omaha, two in Lincoln, and one in Kearney (the geographic middle of the state) – targeting individuals across Nebraska who have DD and complex behavioral/mental health issues. These mobile teams work closely with individual teams onsite at community programs to tailor remedial steps to meet individuals' needs. They provide prompt response to individual behavioral situations with greater flexibility to better meet the needs of each person and situation. A primary goal of the mobile service is to reduce contact with psychiatric hospitals, local hospital emergency departments, and other

restrictive settings. The six teams provide effective statewide coverage; teams can get to almost all individuals in need within one hour.

The monitor concluded that the mobile team service "appeared to assist individuals to maintain their services in community settings, while assisting community providers to improve the services they provided." *Id.* at 14. She applauded the State for the teams' focus on efforts to "build providers' capacity for behavioral treatment planning and implementation." *Id.* She found that the team was "providing valuable input that was beneficial to individuals and community providers" and that mobile services yielded "positive" results. *Id.* at 72, 88.

b. Community-Based Short-Stay Crisis Home

In its findings letter, the United States reported that the State operated a small crisis center – the Intensive Treatment Services unit – on the BSDC campus for individuals living in the community who were experiencing acute behavioral or mental health episodes.

A few years after entering into the Agreement, the State closed the crisis unit on the BSDC campus. In its place, the State opened a small, dedicated, short-stay crisis stabilization program in a community home. As with the mobile teams, this home exists to prevent individuals with DD in crisis from having contact with hospital emergency rooms, psychiatric hospitals, and other restrictive settings.

This home is intentionally small – it serves only three individuals at any given time. As was intended, individuals placed in this home generally stay only a short time before being returned to permanent community homes.

The monitor concluded that this crisis home "was meeting the need for this type of support" and that the State was prepared to create additional capacity if needed. *Id.* at 97.

c. Other State Initiatives for People with Complex Behaviors/Mental Illness

The State has undertaken other initiatives to better address the needs of those with DD and complex behavior issues and/or mental illness in the community, such as providing intensive face-to-face, hands-on training for community providers at various locations across Nebraska to assist them to conduct adequate functional assessments and develop effective behavior plans.

As a result, the monitor concluded that functional assessments and behavior plans in the community have continuously improved. She found that safety plans for individuals were "generally improved," and were often "extensive and detailed." *Id.* at 76. She encouraged the State to continue to provide training and technical assistance to community providers to resolve outstanding behavioral issues. *Id.* at 14, 76, 243. The State pledges to do this going forward.

d. Psychiatric Care

The State has taken a number of steps to expand community capacity to meet the needs of those with DD and mental illness. The State sent its clinical team to review and re-assess high-risk individuals to address lingering concerns associated with polypharmacy or high doses of psychotropic medication. The monitor noted that the team's suggestions were "helpful" to delivery of appropriate psychiatric care to meet mental health needs. *Id.* at 78-80. The State has since engaged in additional outreach to community providers to offer more technical assistance.

Managed Care - The State recently transferred behavioral/mental health services to a managed care entity for individuals receiving Medicaid. The shift to managed care has the potential to provide better oversight of, and to improve services delivered by, community mental health clinicians. Through the managed care organization, the State is developing measures to impose comprehensive reforms throughout the community through adoption of treatment protocols endorsed by the American Psychiatric Association that would prompt better treatment

and improved outcomes. The State pledges to continue to work closely with the managed care entity to impose more stringent requirements on community mental health clinicians, especially in those cases where individuals are receiving multiple psychotropic medications. The monitor concluded that this initiative has the potential to improve coordination of care, provide better oversight of the use of psychotropic medication, prompt additional opportunities for training, and improve the ability to use data effectively. *Id.* at 78, 80.

8. Community Incidents and Investigations of Serious Incidents

Incident Reporting – In recent years, the State recognized that community providers completed incident reports inconsistently and with variable quality. This limited the State's ability to develop and implement reforms. To address this, the State developed an electronic incident reporting system with a limited roll out in April 2011, and full implementation on January 1, 2014. The electronic system is straightforward and easy to use; it enables staff to record incidents more quickly, more accurately, and more consistently than was possible before with paper reporting. The electronic system provides more quality information more quickly to State leadership and staff, thereby enabling the State to take more prompt and more tailored remedial measures to address outstanding concerns.

The monitor characterized the new electronic system as a "notable improvement." *Id.* at 126. She concluded that this system now provides the State with a tool to "collect information in a timely manner [and] to aggregate information, and generate reports that would assist in the analysis of incident and other data"; it also provided "easier access to and use of incident data by a number of audiences, including State staff … as well as community providers." *Id.* at 126-27.

The State has improved its follow up regarding critical incidents, now taking appropriate steps in a timely manner. The monitor found that although more needed to be done, it was

"positive" that the State's technical assistance staff had begun to use incident data to identify individuals with high numbers of behavior-related incidents over a 60-day period. *Id.* at 129. For individuals with over 10 incidents, the State completes additional analysis to determine if the person needs a specialty consultation; the monitor labeled this a "good use of incident data." *Id.*

Investigations – There were recurring problems with timeliness and follow-through associated with community investigations of serious incidents. The State was not sufficiently notifying community providers in a timely manner so they could take necessary action to protect individuals while the investigation was being completed, including removing the alleged perpetrator from direct contact with individuals; in addition, the State was not giving providers the results of the investigations so that the providers could implement remedial measures. As a threshold matter, existing definitions of abuse, neglect, and exploitation failed to include important events where there was no physical injury; as a result, the State was not investigating many allegations.

Prompted by the Agreement, the State began to implement a series of training and other internal reforms that caused it to investigate certain matters it would have not investigated in the past. The monitor reported that these efforts also produced investigations of better quality; she encouraged the State to take additional steps, such as improving methodologies and properly reconciling evidence to support findings. *Id.* at 15-16, 136. At the time of the monitor's most recent visit, the State was in the final stages of implementing an on-call system to more promptly notify community providers of allegations and direct them to remove alleged perpetrators from direct contact with individuals pending the outcome of the investigation. The State is also now starting to initiate investigations the first day, and to notify providers of the results of

investigations. The State is also implementing a quality review of investigations that should prompt further improvements.

Incidents – Even though the State is facilitating receipt of more types of incidents than before the Agreement and investigating serious incidents more thoroughly, incidents in the community are appropriately low among formerly institutionalized individuals. In this sub-group, for over a year now, there have been no recorded instances of seclusion, mechanical or chemical restraint, or physical restraint outside the context of an approved safety plan, and there has been minimal use of physical restraint or separation. During this period, there were no incidents of attempted theft or larceny, and only a handful of incidents per month involving alleged exploitation, property damage, or peer-to-peer aggression. Only 13 individuals last year from the sub-group had contact with law enforcement and there were no arrests; almost half of the contacts were initiated by the person claiming to be upset, not prompted by staff improprieties. Looking at the broader context, in 2013, at all licensed community sites, the State reported a total of 323 serious incident allegations, with only 35 substantiated for the entire year.

9. Enhanced Community Services to Prevent Contact with Correctional Facilities

In January 2010, the State created the Nebraska Family Help Line to establish a single point of contact to make it easier for families to obtain assistance when they are having a family crisis. This 24/7 line is a collaborative effort within state government and it includes the active participation of the State's DD agency. Last year, about a dozen children with DD were referred through the help line.

The State has developed and implemented a robust plan to divert from jail or prison, individuals with DD who come into contact with the judicial system. In recent years, the State's DD agency has done extensive outreach to county attorneys across Nebraska to educate them

about DD issues. As a result, it is common for these attorneys to contact the DD agency to intervene when someone suspected of having DD is implicated in a criminal matter. If the person is willing to accept DD services, the DD agency then assumes responsibility going forward and, typically, further judicial action/incarceration is avoided.

When individuals decline to accept DD services, the State proceeds pursuant to the state Developmental Disabilities Court-Ordered Custody Act ("DDCOCA"), first operationalized a year after entry of the Agreement. In this circumstance, when an individual has been adjudicated as a person "in need of court-ordered custody and treatment" under the Act, the State Department of Health and Human Services is required to evaluate the individual and develop a plan for custody and treatment in the "least restrictive alternative."

In FY14, the State diverted almost a dozen individuals with DD from correctional facilities and transitioned two individuals out of correctional facilities and into community homes. Since the inception of the program in 2009, the State has spent over $4.2 million on this initiative and has diverted about two dozen people with DD. Not only has the State prevented incarceration for an extended or indefinite stay, it has succeeded in providing these people, almost without exception, with community homes and services. This is a better outcome for people with DD and it eliminates the cost of incarceration.

The State's targeted caseload team, first operationalized in 2014, supports individuals with significant health care and/or behavioral/mental health needs, some of whom are involved in court proceedings. It is the team's responsibility to ensure that all individuals adjudicated under the DDCOCA receive appropriate services and supports in the community to ensure their health and safety so that unnecessary institutionalization does not occur.

10. Enhanced Community Capacity to Provide Meaningful Integrated Day Activities Including Supported Employment

The Agreement requires the State to significantly increase daily community integration activities, including supported employment, community volunteer activities, and community business and recreational outings. Agreement ¶ III.C.59. The Agreement emphasizes that day skills training and related activities are to be provided in the community whenever appropriate: "[t]he State shall emphasize involvement in and with the community, away from the BSDC campus, as much as possible and appropriate, according to each resident's individualized needs." *Id*. ¶¶ III.C.57, 58.

Integrated Community Employment - Prompted by the Agreement, Nebraska is now committed to integrated employment for people with DD. Since its entry, the State has enhanced employment service options, activities, and job experiences with a focus on paid employment in integrated community settings in the general workforce; funded more job training and job coaching to enable individuals to gain skills and to become more independent in integrated settings; changed services and supports to better reflect individualized goals; and provided high school graduates with more options to live and work in their community.

The State's 2015 Employment First policy emphasizes that "employment in integrated settings within the community should be the *priority* service option." The policy starts with a presumption of employability for all and elevates the level of priority of the "career" section of the person's individual plan.

In January 2011, the State revised its two adult waivers to provide greater opportunities for individuals with DD to explore integrated employment. The State now offers vocational planning focused on career planning, job exploration, and job skill development to better enable

individuals with DD to have a normal and successful job search experience. Once employment is obtained, the State offers integrated community employment services to provide job coaching and other supports.

In March 2013, the State surveyed its community personnel, asking them to compare the services people living in the community received in 2007, the year of the United States' findings letter, to the services and supports they were receiving now. Survey results revealed notable improvements with regard to employment, volunteer, and recreational activities in integrated community settings.

The State has significantly increased the number of people with DD who are employed in integrated settings, as well as the number of hours they are working there. From 2007 to 2013, the total number of people with DD who worked in integrated settings increased by over 61 percent from 651 people to 1,050 people. *See* Appendix B-4. As of 2013, the State estimated that over 23 percent of all eligible people with DD in its system were working in an integrated setting. From 2007 to 2013, the number of people working over 10 hours per week in integrated settings increased by 70 percent, and the number of people working over 20 hours per week increased by 77 percent.

This is true employment where people with DD are earning minimum wage or above and are being paid directly by the business in an integrated setting – not in sheltered workshops. The State defined "integrated setting" as a setting in which persons with disabilities interact with persons without disabilities who are not paid to provide services and the interactions are to the same extent that people without disabilities have in comparable situations.

Integrated Community Volunteer Activities - The State has made significant strides in involving people with DD in integrated volunteer activities that enable them to explore and

experience their community, learn skills that may be transferable to future employment, contribute meaningfully to their community, and build self-esteem. From 2007 to 2013, the total number of people with DD who volunteered in integrated settings increased by 185 percent from 380 people to 1,082 people. *See* Appendix B-4. During this period, the number volunteering over 10 hours and over 20 hours per week each increased by over 600 percent.

Integrated Community Recreational Activities - There has been similar progress with regard to participation in integrated recreational activities. From 2007 to 2013, the total number of people with DD who were engaged in recreational activities in integrated settings increased by over 96 percent from 1,510 individuals to almost 3,000 individuals. *See* Appendix B-4. The number involved in over 10 hours of community recreation per week increased by over 160 percent and the number involved in over 20 hours of community recreation per week increased by over 223 percent.

Initiatives to Decrease Reliance on Sheltered Workshops - On January 16, 2014, CMS published regulations strengthening the definition of home and community-based services that would qualify for federal waiver funding; the new regulations became effective on March 17, 2014. On February 26, 2014, several weeks before the new CMS rule became final, the State alerted community providers that the State was raising expectations in alignment with the letter and spirit of the new rule, stating that it "will directly impact any workshop where individuals are not routinely participating in integrated activities," and that sheltered workshops "will be required to be *phased out*" (emphasis added). The State instructed the providers to plan now for transition to more integrated day services.

On July 1, 2014, the State added "day habilitation" to its two adult waivers to provide more flexibility to offer facility-free services to individuals in integrated settings. The State

implemented other revisions that prompt day providers to move away from sheltered workshop services and towards more meaningful day activities in integrated settings.

With regard to integrated day, the monitor concluded: "[S]ince the inception of the Settlement Agreement, the State had worked to expand the community options available to individuals, including both residential and day/vocational opportunities. This had occurred through the expansion of the options available through Waiver-funded services … the expansion of the community provider-base in the State, as well as work with providers interested in changing their service delivery models (e.g., from a work center or day treatment model to programs offering vocational as well as other integrated options for activities)." IE Rep. at 6, 71. She concluded the State's efforts to expand community options for integrated employment and vocational opportunities "clearly had paid off in terms of improved services and opportunities." *Id.* at 88. She reported that she saw "a number of examples of innovative vocational and day opportunities for individuals … progress has certainly been made." *Id.* at 9. She found that "outcomes for individuals across the system appeared to be improving." *Id.* at 8, 86.

BSDC - In its findings letter, the United States noted that Nebraska failed to provide residents with adequate, meaningful, integrated community activities. The United States found that: no resident received programming off campus, *only one* resident worked significant hours in the community, the State focused on day services at sheltered workshops on the segregated campus, the number of residents who participated in community outings was very limited as were the number of days and hours per day, and residents were typically able to go to the community only a handful of times per month, for just a couple of hours each time.

Since entry of the Agreement, the State has taken significant steps to better integrate BSDC residents into the community during the day. In 2014 and the first half of 2015, the State

reported that over 90 percent of BSDC residents participated in off-campus activities at least once per week; this is up from 73 percent in early 2013. Integrated activities include paid work, volunteer work, social and recreational activities, or general activities like shopping.

The number and percentage of BSDC residents working in the community continues to increase from year to year. The percentage of eligible residents who work off campus has increased significantly from less than one percent (one person) at the time of the United States' findings letter, to seven percent in 2010, to about 24 percent in 2011, to about 35 percent in 2012, and to around 60 percent starting in 2013 through to today. *See* Appendix B-5. In the first quarter of 2015, the State reported that 53 BSDC residents were employed in the community, 62 residents were employed on campus, and a total of 88 residents were employed (some work both on and off campus); the State reported that only one eligible resident was not working at all.[7]

BSDC residents work in a variety of community settings – some do custodial work at the Beatrice Police Department, the local chamber of commerce, and AseraCare (an organization that provides palliative care), while others package items at Exmark (a manufacturer of professional turf care equipment). Other residents are involved in various forms of off-campus self-employment, such as lawn mowing, and delivering newspapers on a paper route.

The State is continuing to take important steps at BSDC to further improve outcomes in this area, including assigning an additional manager to the vocational team to increase the focus on integrated employment and career development, implementing new practices to include more thorough consideration of eligibility for employment, developing a better database to track interests and skills that will facilitate job development and placement, increasing collaboration with the local chamber of commerce, a private staffing company, and community employers, and

[7] The State determined that 89 of 120 total residents were eligible for employment (not retired).

providing enhanced job coaching. The State provides onsite job coaches, as well as ongoing training and other supports, for BSDC residents with jobs in integrated settings to ensure they succeed in their community jobs and advance in their careers. To encourage contact with the community, the State also revised position descriptions for BSDC vocational support workers to give them flexibility to follow people into community vocational services.

A significant number of BSDC residents now engage in volunteer activities in the community. Each month, more than 20 residents help deliver food to the needy through the Meals on Wheels program. Residents are active with other community groups including the Humane Society, the Red Hat Society, Grow Big Red (Beatrice beautification project), Nature Abounds, the Salvation Army, recycling entities, as well as various churches and local clubs.

At the time of the United States' investigation, a significant number of individuals *never* left their rooms or living units. The State has now taken meaningful steps to get all residents off their residences to other locations, including the community. In the second quarter of 2014, the State reported that just about everyone at BSDC engaged in five or more hours per day of skills training away from their home residence. The State reported that only one resident did not meet this criteria because he was on hospice and could not tolerate the hours away from his residence.

The monitor concluded that State efforts to increase vocational opportunities at BSDC to better meet individualized needs in integrated settings have "yielded positive results." IE Rep. at 156. She reported the State had effected a "conceptual shift" regarding the role of the on-campus home rooms, "de-emphasizing them as primary habilitation sites in favor of community-based vocational and other opportunities." *Id.* at 159. She found that neither transportation nor staffing issues were a barrier to community integration activities. *Id.* at 158.

11. Internal DD Agency Actions to Enhance Community Services

The State has taken a number of other important internal steps to expand and enhance community capacity so as to better meet the needs of people with DD in the community and to minimize the risk of institutionalization.

Service Coordination – After entry of the Agreement, the State transformed its old "case management" system into a DD "service coordination" system where personnel now actively advocate for each individual. The State maintains small caseloads for service coordinators of no more than 25 individuals per service coordinator. The monitor reported that service coordinators "clearly knew the individuals and their provider staff" and were therefore better able to address their individualized needs. *Id.* at 137.

Serving Individuals with Complex Needs – In addition to the State's mobile teams, in 2010, the State created an internal technical assistance team to provide expert input and guidance to community providers. The team provides technical assistance by phone, email, in person, and in formal meetings and training opportunities. Since its creation, the team has handled hundreds of requests for information or assistance from community providers.

III. INSTITUTIONAL REFORMS IMPLEMENTED AT BSDC

A. Safety and Protection from Harm

1. Settlement Agreement Requirements

The principal requirement of this section of the Agreement is that the State will "provide residents with a reasonably safe and humane living environment, which includes that the State shall: (1) protect residents from abuse and neglect; and (2) take effective steps to minimize or eliminate resident injuries and other significant incidents that may negatively impact their health, safety, and welfare." Agreement ¶ III.A.1. Specific provisions require the State to:

- ensure that individuals are free from abuse and neglect in a "zero-tolerance" environment;

- minimize incidents that may adversely impact the health, safety, and welfare of individuals, especially those incidents that result in serious injury; and

- implement prompt and effective measures to address all issues and recommendations associated with investigations to ensure that individual outcomes are achieved.

Id. ¶¶ III.A.2, 10, 14, 16, 18.

2. Overall Incident Numbers at BSDC

In its 2007 findings letter, the United States reported that BSDC was an unsafe environment, where serious incidents and injuries were common.

Incidents/Serious Incidents – Since then, the State has implemented effective reforms to heighten safety. There has been a downward trend of serious incidents over time. In 2013, there were 26 serious incidents reported with only four injuries of unknown origin and just one elopement; the 2013 serious incident numbers represent a 50 percent reduction from as recent as 2011. Progress has been sustained: in the first two quarters of 2015, there were only13 serious incidents, two injuries of unknown origin, and just one elopement – all figures at the same or improved annual rates as in 2013. *See* Appendix B-6.

Overall, the monitor found that the State has implemented effective measures to identify, discuss, and address systemic safety issues; she also noted that the State has implemented action plans to address outstanding issues. IE Rep. at 17-19, 41-42, 45. She reported that the State had implemented effective measures to identify root causes and whether or not incidents were preventable. *Id.* She attributed success here, in part, to better staff training and improved behavior plans and implementation. *Id.*

Peer-to-Peer Aggression - In its findings letter, the United States found that peer-to-peer aggression was rampant at BSDC; in the year before its onsite visit, the United States found that there were over 100 different residents who were characterized as aggressors in well over 500 separate incidents, many of which caused an injury to a resident.

Since that time, the State has undertaken significant efforts to reduce incidents of aggression between peers. In 2013, there were only 42 incidents of peer-to-peer aggression; this represents a 91 percent reduction from the time of the findings letter. No incident of peer aggression in 2013 resulted in significant physical harm. The number of peer-to-peer incidents and injuries has continued to stay low. In 2014, there were only 21 peer-to-peer incidents and no incident resulted in significant physical harm. In the first half of 2015, there have been 23 such incidents, but only one minor injury and again no significant injuries. *See* Appendix B-6.

The monitor reported that the State has made and sustained progress in addressing outstanding issues associated with peer-to-peer incidents. IE Rep. at 17, 46. She found that there were decreasing trends with regard to the number of incidents, numbers of victims, and number of aggressors. She wrote that she "commends Facility staff for their commitment to and active pursuit of reducing risk in relation to peer-to-peer incidents of aggression. These efforts clearly have resulted in improved quality of life for individuals the Facility serves." *Id.*

3. Abuse and Neglect at BSDC

In its 2007 findings letter, the United States concluded that the nature and frequency of abuse and neglect at BSDC suggested a "cultural undercurrent that betrays human decency at the most fundamental levels … basic human dignities are violated with considerable regularity." In the year before the United States completed its onsite review, there were over 200 incidents at BSDC that involved an allegation of abuse or neglect, with over half of these later substantiated.

The United States' findings letter contained numerous individual examples of substantiated physical abuse and neglect of residents, often resulting in a serious injury to the individual.

Per the Agreement, the State now maintains a "zero tolerance" policy for abuse and neglect. The State developed broad definitions of abuse and neglect that include verbal abuse and exploitation. The monitor found these definitional revisions were "important changes" that supported the State's commitment to zero tolerance for abuse and neglect. IE Rep. at 27.

State policies at BSDC require staff to promptly attend to any residents involved in an abuse/neglect incident and ensure they are safe. Per the Agreement, the monitor concluded that the State was now removing alleged perpetrators from direct resident contact whenever there was an allegation of abuse or neglect. She also concluded that the State was imposing appropriate discipline, including termination, whenever allegations were substantiated.

The State's zero tolerance policy stresses that any substantiated act of abuse, neglect, or mistreatment may result in termination of the employee, as would failure to report witnessed acts of abuse or neglect. Since at least 2012, the State has fired every single employee who was found to have committed substantiated abuse or serious neglect. The State even fires employees who fail to report suspected abuse or neglect in a timely manner.[8]

Substantiated abuse incidents at BSDC have continued a steady path of decline: at the time of the United States' findings letter, there were over 100 reported instances; in 2011, there were 11 reported instances; in 2012, there were five such instances; in 2013, there were three

[8] On November 10, 2014, in *Essman v. Nebraska Dep't of Health and Human Servs.*, Civ. No. A-13-840, the Nebraska Court of Appeals affirmed a decision of the district court of Lancaster County that upheld the termination of a BSDC employee who failed to promptly report an abuse allegation. The court referenced the State's "zero tolerance" policy, imposed per the Agreement. This action and decision have had a positive and chilling effect on any would-be abusers; it sent a strong message to all that abuse and neglect will not be tolerated.

such instances; in 2014, there were only two instances, and there was no reported substantiated abuse in the first two quarters of 2015. The same downward trend is present with regard to neglect at BSDC. In 2014, the State reported a total of eight instances of substantiated neglect, with only one instance in the first half of 2015. *See* Appendix B-7. Combined abuse/neglect figures thus far in 2015 project to an annual total of only two substantiated instances of abuse and neglect at BSDC.

In 2011, it emerged that there had been very troubling staff abuse of some residents at BSDC that was hidden from State leadership. After a close examination, the United States determined that these incidents were isolated and not reflective of conditions and practices throughout BSDC. Given the serious nature of the abuse, we discuss the circumstances in more detail in Appendix C, attached to the accompanying index of evidentiary materials.

4. Improved Internal Processes to Minimize Risk of Harm at BSDC

In its findings letter, the United States found problems related to the facility's incident management system that contributed to further risk of harm. The United States also found a number of problems with the investigation of serious incidents at the facility, as well as with the implementation of needed corrective measures associated with investigation recommendations.

Incidents and Investigations - Today at BSDC, there is an adequate incident management policy in place with appropriate reporting requirements and follow-up procedures. The State maintains a database on incident data, analyzes the data, and determines whether or not incidents were preventable. The State has instituted daily incident meetings to review incidents that occurred the previous business day, make recommendations on how to address any outstanding issues, and track implementation of the recommendations. As a result, the monitor concluded: "Since the beginning of the implementation of the Settlement Agreement, improvement had

occurred with regard to the analysis of incidents and allegations." IE Rep. at 17, 41-42. She also praised the State for working to "ensure that if analyses showed problems or trends related to incidents and allegations, action plans were developed to address them." *Id.* at 17, 42.

The monitor concluded that the State has also complied with requirements related to investigations, including their timely initiation and completion, thoroughness, reconciliation of evidence, and providing an adequate basis for findings. *Id.* at 17, 48. Investigations now commence at least by the next working day of the incident being reported and they are completed within 30 days. *Id.* at 47. The monitor concluded that the investigations at BSDC were thorough, provided an adequate basis for findings, and showed "improvement over time." *Id.* at 48. She found there was ongoing improvement with regard to the quality, thoroughness, and the measurability of action plans. *Id.* at 17, 35, 41.

For several years now, the State has been forwarding to the local county attorney and appropriate law enforcement officials pertinent information associated with certain investigations that might lead to a criminal case. The monitor applauded this and concluded that there was clear collaboration with law enforcement. *Id.* at 49.

Quality Assurance - There is now an adequate quality assurance system in place at BSDC on multiple levels and this has had a positive impact on incidents and overall risk of harm. The State's quality improvement structure identifies problematic trends, analyzes their causes, implements measures to address suspected causes, and evaluates their effectiveness. The State has developed indicators addressing important aspects of service quality and of critical outcomes, including health, well-being, and independence. The monitor concluded that quality improvement activities are ongoing and deepening and that they produce action plans that are implemented, and typically produce "improvements" for individuals. *Id.* at 18-19, 45-46.

B. Behavioral Services, Restraints, and Psychiatric Care

1. Settlement Agreement Requirements

The principal requirement is that the State will provide adequate behavioral services to meet the needs of each person to provide a reasonable opportunity to "enhance functioning, to grow and develop, to attain self-help and social skills needed to exercise as much autonomy or independence as possible, to prevent or decelerate both physical and psychological regression, loss of skills and functional status, and to ensure their reasonable safety, security and freedom from undue bodily restraint." Agreement ¶ III.C.54.

The Agreement requires that "all residents [be] free from unreasonable restraint," to remove restraint as an acceptable form of planned behavioral intervention, and to develop steps such that the use of restraints will become "a very rare occurrence." *Id*. ¶¶ III.C.72-73, 77.

2. Improved Behavioral Services

In its findings letter, the United States concluded that the State failed to provide adequate behavioral services for dozens of BSDC residents with behavior problems. The United States reported that this deficiency contributed to poor outcomes, including injury, abuse, the use of highly restrictive interventions, and decreased opportunities for placement in community settings. BSDC behavior plans typically included some form of restraint element, such as multi-point restraints where people were tied to beds with cloth and leather straps with buckles.

Functional assessments and behavior plans at BSDC now include all required components, including procedures to decrease problem behaviors, developing and strengthening replacement behaviors, active skill acquisition techniques, individualized reinforcers, environmental elements, and data collection systems. The State now implements the behavior plans in a timely manner. The monitor concluded that "the practice of functional behavior

assessment at BSDC appeared to be generally in line with expectations described in the Settlement Agreement." IE Rep. at 152. She found that BSDC behavior plans generally meet the requirements of the Agreement and that revised plans showed "significant improvement" in areas previously found problematic. *Id.* at 160-63. The monitor found the State has "made good progress" implementing quality behavior plans. *Id.* at 161, 163.

3. Drastic Reduction in the Use of Restraints

In its 2007 findings letter, the United States concluded that the State subjected BSDC residents to undue restraint. The United States characterized injuries and incidents associated with restraint usage at BSDC as "alarming and disconcerting." The United States reported that BSDC routinely utilized physical restraints, as well as invasive multi-point mechanical restraints, often tying down a person's two arms, two legs, and upper torso with straps, and the facility used physical and mechanical restraints on both an emergency basis and as a planned intervention.

Mechanical Restraints – At the time of its investigation, the United States' psychology consultant concluded that mechanical restraint usage at BSDC was "the highest in frequency and duration that I have seen in my experience." The United States found that dozens of residents were subjected to tens of thousands of minutes of planned mechanical restraint.

One of the most significant accomplishments of the Agreement is the complete eradication of mechanical restraint usage in the Nebraska DD system – at BSDC, at Bridges, and in the community. This is a direct result of reforms implemented per the Agreement. In January 2011, the last mechanical restraint was used at Bridges; in December 2011, the last mechanical restraint was used at BSDC; and mechanical restraints have not been used at all in the community since the entry of the Agreement.

Physical Restraints - In 2008, about 21 percent of BSDC residents – about six dozen individuals – were subjected to physical restraints. There were 539 instances of physical restraint that totaled 2,660 minutes. In the first half of 2015, there were only 19 instances of physical restraint for a total of 106 minutes; this represents more than a 90 percent reduction in the annual use of physical restraints at BSDC from the first year of the Agreement. *See* Appendix B-8. In the second quarter of 2015, only three individuals (about two percent of the BSDC census) were subjected to physical restraint, a total of 10 times, for a total of 59 minutes.

The reduction is due directly to changes implemented per the Agreement – programmatic physical restraints are no longer permitted, physical restraints may only be utilized as emergency safety interventions, and the State constantly works towards zero use of physical restraint. State policies on restraints are now consistent with requirements of the Agreement.

Overall, the monitor reported that data showed "significant declines in the use of restraint." IE Rep. at 20. She found that use of restraints has become a "rare occurrence." *Id.* at 174. She concluded that the State is to be "commended for marked positive changes in attitudes and practices with respect to responding to behavioral crisis situations." *Id.* at 20. She reported that injuries related to restraints are "low," and that in 2013, there were only two minor injuries related to a physical hold. *Id.* at 170.

The State was able to significantly reduce physical restraints and completely eliminate mechanical restraints at BSDC without increasing the use of psychotropic medications; indeed, the percentage of residents prescribed psychotropic medications has decreased in recent years.

4. Improved Mental Health Services

In its findings letter, the United States concluded that the State failed to provide adequate psychiatric services to individuals with co-occurring mental illness. The United States found that

psychotropic medication usage at BSDC was very high, that the incidence of psychotropic polypharmacy was high, and that some individuals were "grossly overmedicated."

The State is now providing BSDC residents with adequate routine and emergency psychiatric services. There are sufficient psychiatry hours now to meet the mental health needs of those at BSDC, including enough time to complete thorough evaluations, develop carefully considered differential diagnoses, order appropriate treatments, and provide needed follow up. The monitor found that if needed, residents could be seen "quite frequently." *Id.* at 178.

The monitor concluded that psychiatric care at BSDC was an area in which "significant improvement had been achieved over time." *Id.* at 21. Positive areas include development and implementation of proper psychiatric treatment plans, incorporation of behavioral data into the decision-making process, and better coordination between psychiatrists and other professionals. The State conducted a review to bring all psychiatric diagnoses in line with current DSM criteria; there is now adequate justification for psychiatric diagnoses at BSDC. The monitor found that psychiatrists were "paying close attention to the diagnostic criteria when making diagnoses, which potentially was also having a positive impact on treatment." *Id.* at 21-22, 180.

The monitor reported that there were "ongoing attempts to manage individuals on the lowest necessary dose of [psychotropic] medications, and to minimize the number of medications the individuals were prescribed." *Id.* at 181. Psychiatrists regularly review the current medication regimen of each individual to determine whether or not the types and dosages of medication are appropriate and necessary, and then make changes when needed.

At the outset of this case, there were over 150 BSDC residents taking at least one psychotropic medication; today, that number has been cut by more than half. This decrease is due in part to the reduction of the overall census, but it is also the product of a concerted effort to

minimize the use of these medications. Reduced reliance on psychotropic medications decreases the risk of adverse consequences associated with medication side effects.

The number of residents who are subjected to psychotropic polypharmacy has been decreasing. For the past year, there have been only six residents who were taking two or more psychotropics; this yields a polypharmacy rate of under 15 percent among those taking psychotropic medication, and a rate of around five percent of the total BSDC census.

In 2014, there were only eight instances of emergency use of psychotropic medication at BSDC, even though there were over 90 behavioral crisis episodes. During the first two quarters of 2015, there were 36 behavioral crisis episodes, with only a handful involving emergency use of medication. This is a testament to the State using less onerous practices to deal with crises. The monitor reported that it was "impressive" that psychiatrists have refrained from increasing reliance on medications when behaviors escalated. *Id.* at 180.

The monitor reported that the State does a "good job" monitoring side effects and related health markers. *Id.* at 181. She also concluded that the State has adequately addressed concerns raised in earlier monitoring reports with regard to providing guardians with sufficient information to make fully informed decisions with regard to mental health care. *Id.* at 21.

C. Health Care and Related Services

1. Settlement Agreement Requirements

This section of the Agreement requires the State to provide individuals with adequate, appropriate, and timely preventive, routine, acute, and emergency health care to meet the individualized needs of each person. Agreement ¶ III.D.90. The Agreement includes provisions on medical care, neurological care, nursing services, nutritional and physical supports, and various therapeutic interventions. *Id.* ¶¶ III.D.92-140. The Agreement establishes a priority

group for "heightened and enhanced attention and focus"; this includes those with a seizure disorder and those at risk of suffering a bowel obstruction, an aspiration event, a decubitus ulcer, a fracture, or an event associated with other at-risk conditions. *Id*. ¶ III.D.97.

2. Improved Health Care

In its findings letter, the United States found that the State failed to provide BSDC residents with adequate health care. The United States found that health care was more reactive than proactive, especially with regard to individuals with complex, high-risk conditions.

Improved Clinical Practices – Since entry of the Agreement, the State has implemented a host of improved health care practices to better meet the needs of BSDC residents, including those with more involved health conditions:

- The State is now providing BSDC residents with timely health care evaluations. The State has implemented an electronic system to ensure that referrals and testing procedures are completed and results are available in a timely manner.

- The State makes prompt referrals to specialists when needed. The State has also addressed issues associated with providing critical health care information to them.

- The State has begun to implement an electronic health record that facilitates the delivery of care and services, improves clinical work flow and communication, enhances implementation of quality assurance measures, and helps achieve positive outcomes.

- The State properly utilizes a health care screening tool to better ensure provision of routine and preventive health care based on individual needs. The State is appropriately identifying a priority group of individuals with high health risks. Individuals in this group receive individualized and appropriate health care that produces desired outcomes.

Quality Assurance - The State has expanded its quality assurance system at BSDC to better ensure that it is taking an individualized and comprehensive approach to meet each person's needs and it has integrated health quality assurance processes with the larger quality assurance system. The monitor concluded that "[a]ttention to closing the loop between medical audits and necessary corrective actions was apparent." IE Rep. at 194.

Nursing - Nursing services at BSDC have improved since the entry of the Agreement. In general, properly trained staff now provide appropriate nursing services to meet individualized needs. Nurses utilize appropriate nursing assessment tools, flow sheets, and tracking records and make timely changes to care plans whenever issues arise. The monitor has endorsed the following nursing reforms and improved practices:

- The State has implemented a comprehensive, workable system to ensure that nurses are documenting accurately; the monitor concluded that these efforts have a "positive impact" on delivery of quality care.

- The monitor concluded that there was "significant improvement" in nursing plans and that they were "individualized and provided an understanding of needed daily care elements." The primary nurse or supervisor makes changes to individual nursing plans as needed and then the health care coordinators communicate the changes to other team members; the monitor concluded that this system was "functioning well."

Id. at 205, 206.

Outcomes - Since entry of the Agreement, the health care reforms implemented at BSDC have produced positive outcomes. Here are some examples:

- In 2009, BSDC residents made 260 visits to a hospital emergency room or were admitted to a hospital for serious health care issues. Since then, the number of hospital contacts has decreased steadily to only 76 contacts in all of 2013; this is a reduced rate even accounting for the census drop. In the first two quarters of 2015, there has been a further reduction with only 33 individuals having such hospital contacts.

- There is an overall downward trend in the incidence of pressure ulcers at BSDC. In 2014, the average number of residents with new pressure ulcers per the overall census was only 0.8 percent; there was only one pressure ulcer recorded per quarter. In the first two quarters of 2015, no BSDC resident had a pressure ulcer.

- The medication error rate at BSDC is very low, and since 2013, no medication error has produced a harmful outcome for involved individuals.

Seizure Disorders - The State now provides BSDC residents with seizure disorders with appropriate neurological care. Clinicians provide a proper documented rationale for treatment and engage in active efforts to reduce anticonvulsant polypharmacy. There is now sensitivity to

the need to manage medication to minimize adverse side effects. The State compiles and uses appropriate seizure data throughout treatment. The monitor reported that the State has developed "seizure needs" plans and has trained staff on how to implement them; these plans include information on how to properly address status epilepticus. *Id.* at 199. All disciplines communicate well to provide coordinated care, the State provides specialty consultations when needed, and uses seizure data as a part of service delivery.

3. *Improved Physical and Nutritional Supports, Therapies, and Communication Services*

In its findings letter, the United States found that residents did not receive adequate PNS at BSDC. The United States found that the facility did not provide adequate occupational therapy, physical therapy, or speech therapy, and that assistive technology resources were inadequate to meet the needs of the individuals.

Physical and Nutritional Supports - Since entry of the Agreement, the monitor reported that the State had made "significant progress" in providing PNS to meet individualized needs at BSDC. *Id.* at 22. The monitor concluded that the State "continued to develop, revise, and implement a sustainable system for the provision of physical and nutritional supports for individuals with identified needs." *Id.* at 221. The monitor concluded that the State had made "significant improvements" in this area. *Id.* at 217-20.

In April 2010, the State created a PNS team to provide proactive care and services to people with dysphagia and those who aspirate or are at risk of aspiration to minimize risks associated with choking, aspiration, pneumonia, skin breakdown, and nutritional decline.

The State works to ensure implementation of proper mealtime and positioning strategies throughout the day for at-risk individuals, as well as enhanced nursing oversight and monitoring of signs and symptoms. The State has taken a number of important steps:

- The State has developed reasonable methodologies for identifying individuals in need of supports, through multiple pathways including screening tools and change of status data.

- The State now conducts regular "status change" meetings to alert team members of residents who might be in the early stages of experiencing a change in status. The monitor applauded this new practice, as it produced more proactive service-delivery.

- The monitor reported that the State now performs individualized positioning evaluations to reduce the risk of aspiration and concluded this was very positive.

Id. at 23.

The monitor concluded that team interventions over the years have "significantly improved outcomes for individuals." *Id.* at 22. She found that the State had "successfully transitioned to intervening more proactively with individuals and providing timely PNS services and supports." *Id.* at 23, 232. As a result, choking incidents are down in recent years and the incidence of pneumonias, including aspiration pneumonias, has decreased.

Therapies - The State now complies with Agreement requirements with regard to physical and occupational therapy assessments. The monitor concluded that the State has "adequate templates, including guiding questions, and policies [and that] OT/PT assessments were comprehensive and addressed the assessment components as outlined" in the Agreement. *Id.* at 227. She reported that the State had "developed and implemented a number of processes aimed at improving outcomes for individuals." *Id.* at 233. She concluded the State "continued to be committed to expanding the number of individuals who received therapeutic positioning in multiple environments … to minimize and/or reduce their risk factors." *Id.* at 235.

The State created a specialty multi-disciplinary neuromuscular spine and gait services clinic to address the needs of those with physical disabilities. The State also improved practices associated with fabrication, modification, and repair of wheelchairs and other adaptive

equipment. The monitor concluded that the improved processes were sustainable and "significantly improved outcomes for individuals" at BSDC. *Id.* at 22.

Communication - The State is now providing direct speech and language therapy to an increased number of individuals. The monitor noted the State was now integrating individualized communication assessments and strategies into annual plans and implementing measures to provide enhanced communication services/supports in multiple environments. *Id.* at 24-25. The monitor concluded that the State had implemented "major positive revisions to the [] assessment format, especially in the area of [communication] assessment … Competency-based training also had been provided to ensure staff knew how to use and assist individuals with the devices." *Id.* at 24-25, 240-41.

4. Mortalities

In its findings letter, the United States found that some individuals with DD in the State's system appeared to have suffered preventable deaths. The United States noted that there was no in-depth root cause analysis of each death to determine if the course of care in the weeks prior to the death was inadequate.

Independent Mortality Investigations – The Agreement requires the State to create an independent and external mortality review committee to conduct in-depth death reviews and to issue written reports to identify preventable causes so that similarly situated individuals would not suffer preventable illness or death. Agreement ¶ III.D.106. The State is to then ensure prompt and effective implementation of the committee's recommendations. *Id*. ¶ III.D.108.

The State contracted with the Columbus Organization to conduct the independent mortality investigations for individuals in the institutional sub-group. Typically, a doctor and a nurse with DD experience conduct the reviews. This process has been positive and rigorous;

Columbus has produced in-depth, independent reviews to expose weaknesses in the State's service-delivery system. The reports are well-written and contain findings, more exact and accurate causes of death, concerns associated with the death (if any), and individual and systemic recommendations to help avoid preventable illness and death going forward. The State provides a copy of the Columbus reports to the community providers to prompt needed remedies. The State also provides a copy to the regional DD office and the Division of Public Health, for systemic follow up.

Community – In May of this year, the State issued its second annual report on deaths for the thousands of people with DD in the State's system. The State reported that 65 individuals died in integrated community settings in Nebraska in 2014. Almost one-third of the people who died in 2014 were on hospice care. Mortality rates for the past two years in Nebraska are favorable, and reflect positively on the State's DD system as a whole. The State commits to making the annual mortality report a public document this year and going forward.

BSDC – In 2009, the first full year under the Agreement, 25 individuals from the institutional sub-group died; this was largely due to the trauma associated with an unexpected emergency evacuation order from the State Department of Public Health in February 2009, that mandated the removal of about four dozen medically fragile individuals from BSDC because BSDC was not able to deliver effective health care services to individuals with complex health needs. Within a year of that emergency order, a dozen displaced individuals had died. We discuss this evacuation order and the individuals impacted by it in greater depth in Appendix D, attached to the accompanying index of evidentiary materials.

Community capacity started to expand and meaningful reforms took root for the first time in 2010. From January 1, 2010 through April 2015, a total of 59 individuals with DD from the

sub-group have died, averaging less than a dozen deaths per year; almost two-thirds of those died while residing in an institutional setting, such as BSDC or a nursing home.

IV. CONCLUSION

For the reasons set forth above, the parties jointly ask the Court to find that the information contained in this memorandum in support is sufficient to enable the Court to dismiss this case with prejudice given the State's sustained compliance with the terms of the remedial Settlement Agreement in this case.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on July 22, 2015, I electronically filed the memorandum in support of the parties' joint motion to dismiss with the Clerk of the Court using the Court's electronic case filing system, which will serve copies of the document on all parties of record.

Respectfully submitted,

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