2005 Annual Report

MCCP

Prepared for the Metro Regional Crisis Planning Group

Executive Summary

Metro Crisis Coordination Program continues to assist the Metro Regional Crisis Planning Group (MRCPG) meet challenges in the Metro crisis system for people with Mental Retardation and Related Conditions. 2005 proved to be a year of consolidation and continued regrouping after the State budget crises in 2002. MCCP and the MRCPG used 2005 to take stock of where the crisis system is now and begun laying plans to ensure that the system is able to meet the growing needs and demands of the people that the system is charged to serve.

Highlights of 2005 include:

- Meridian Services opened four bed crisis home in Plymouth for children and adolescents. During the year, Meridian served 24 children and adolescents. Their average length of stay was 43.3 days and they maintained an 82% occupancy rate.
- The MRCPG selected Hammer, Incorporated to develop a children's and adolescent transition home. At the end of 2005, Hammer had purchased a home and begun renovations. A spring 2006 opening is planned.
- State operated crisis homes moved to a single rate. The work begun by members of the MRCPG and MCCP bore fruit when Minnesota State Operated Community Supports (MSOCS) took over two metro crisis homes and implemented the single rate.
- The cornerstone of MCCP and the MRCPG's vision to secure the crisis system for future users continues to move forward. The Pooling Allocation Project, a joint venture between the seven metro counties and MCCP, took significant steps towards realization in 2005. The seven metro counties agreed on the dollar size of the crisis system they wished to fund and received approval from Minnesota DHS. The Project has an implementation date for April 2006. The project should provide MRCPG's member counties with important advantages, such as a relatively fixed cost for crisis ser-

vices, limit drastic cost overruns, control costs so complete and suitable services are available now and in the future, as well as streamlining access to crisis services. The Executive Summary for the Project can be found in Appendix II.

MCCP Financial Position

MCCP saw a loss for the year of $106,000. The loss can be attributed to several factors, including:

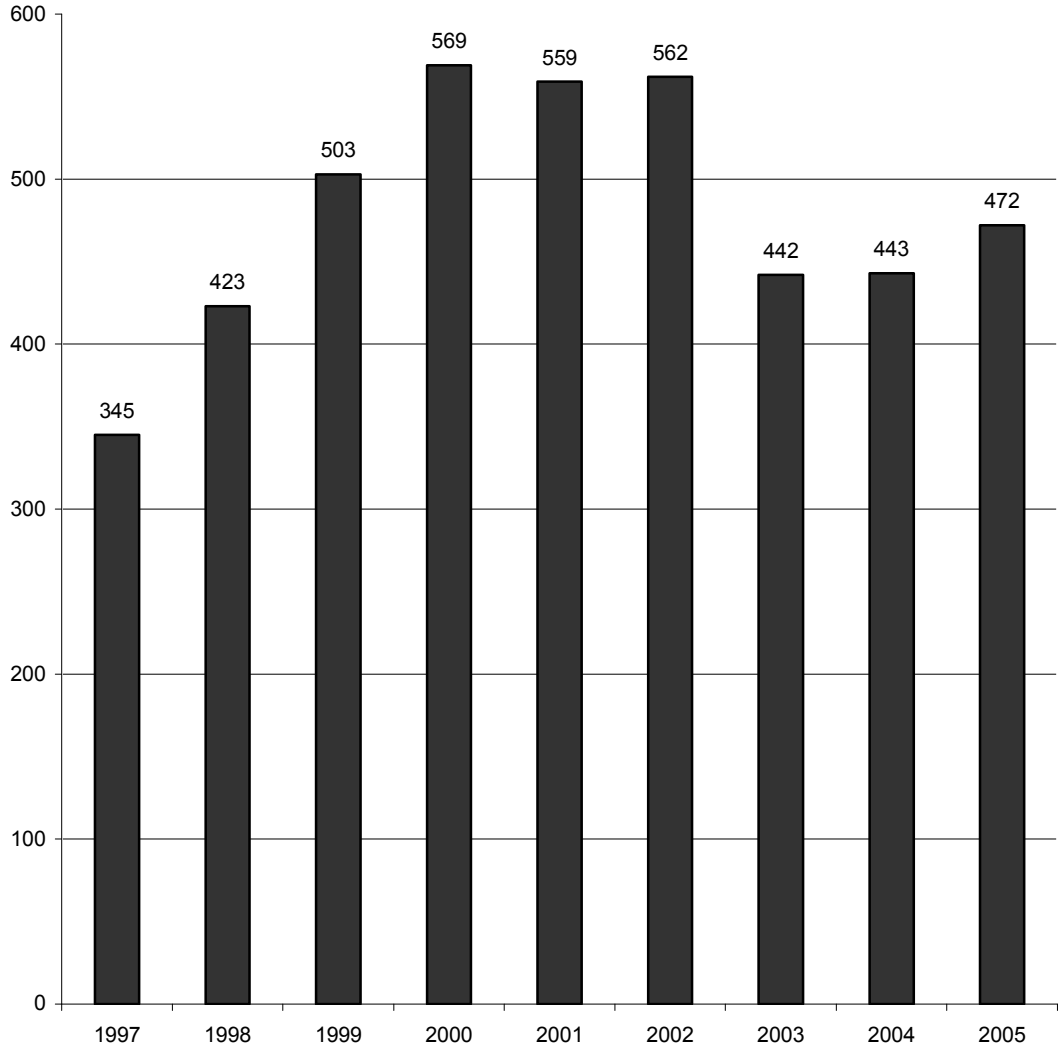
- 16% fewer referrals from 2002;
- Increase in unpaid/unfunded cases from the original estimate used to develop a rate for MCCP. At inception, the MRCPG and MCCP predicted 15% of incurred units would be unfunded. By March of 2005 that number had grown to 33% (average of 26.6% for years 2002-2004);
- Additional unfunded responsibilities taken on as MCCP and the MRCPG move towards a managing entity model for the crisis system. These responsibilities include:
    - Attendance at crisis homes for admission, 14 day, 30 day, and discharge meetings. Average length of stays are slightly below or slightly above 45 days, doubling the capacity of the crisis home with no dollar outlay on the part of the member counties, but requiring at least one FTE at MCCP to oversee the admissions and demissions.
    - Gathering of data for MRCPG and their supervisors;

In conjunction with the Project, MCCP has begun to offer services for its traditional clients through funding mechanisms other than the MR/RC Waiver. In Scott County, MCCP provided CADI ILS services. MCCP has also started the application process for Children's Therapeutic Support Services (CTSS), and will begin the process for Adult Rehabilitative Mental Health Services (AHRMS). MCCP also has on staff appropriately credentialed professionals who can direct bill MA.

MCCP remains optimistic that the high level of services that have supported people with Mental Retardation and Related Conditions for nine years will continue with the start of the Managing Entity Project.

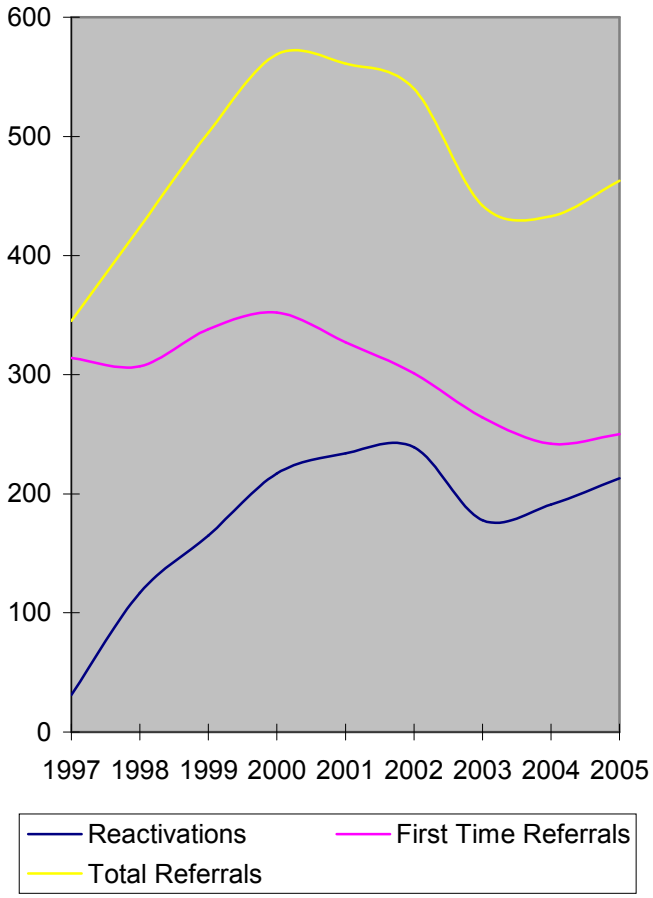
Referral Information

Overall referrals to MCCP inched up in 2005, from 443 in 2004 to 472. While the overall total remains significantly lower from the referrals in 2000-2002, referral activity has increased. Two interesting pieces of data: 22% of referrals were for Information and Referral, which will be discussed later, and almost half of referrals were reactivations (Please see chart).



Referrals To MCCP By Year

The chart at left illustrates the number of first time referrals and reactivations. One would expect that reactivations would increase over time. Additionally, one could also discern some of the reasons that would lead to an upward trend in reactivations. Those reasons could include:

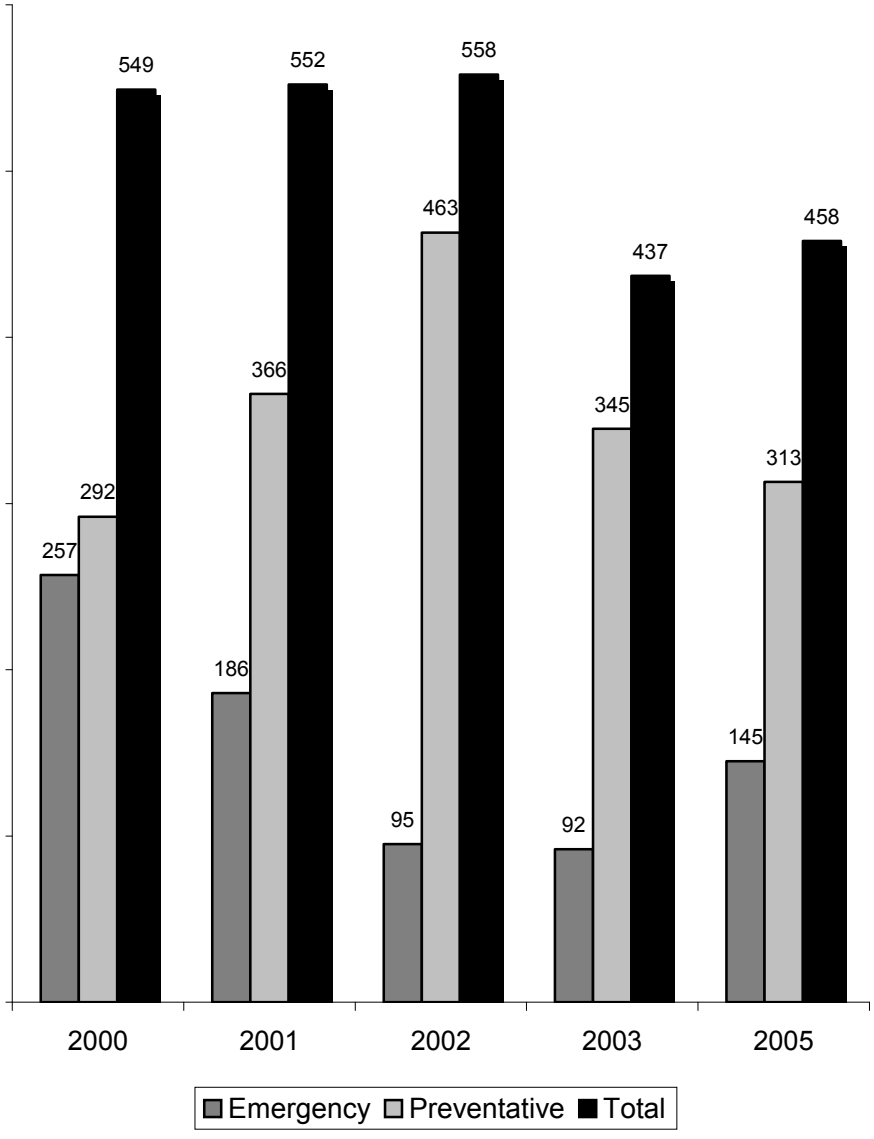


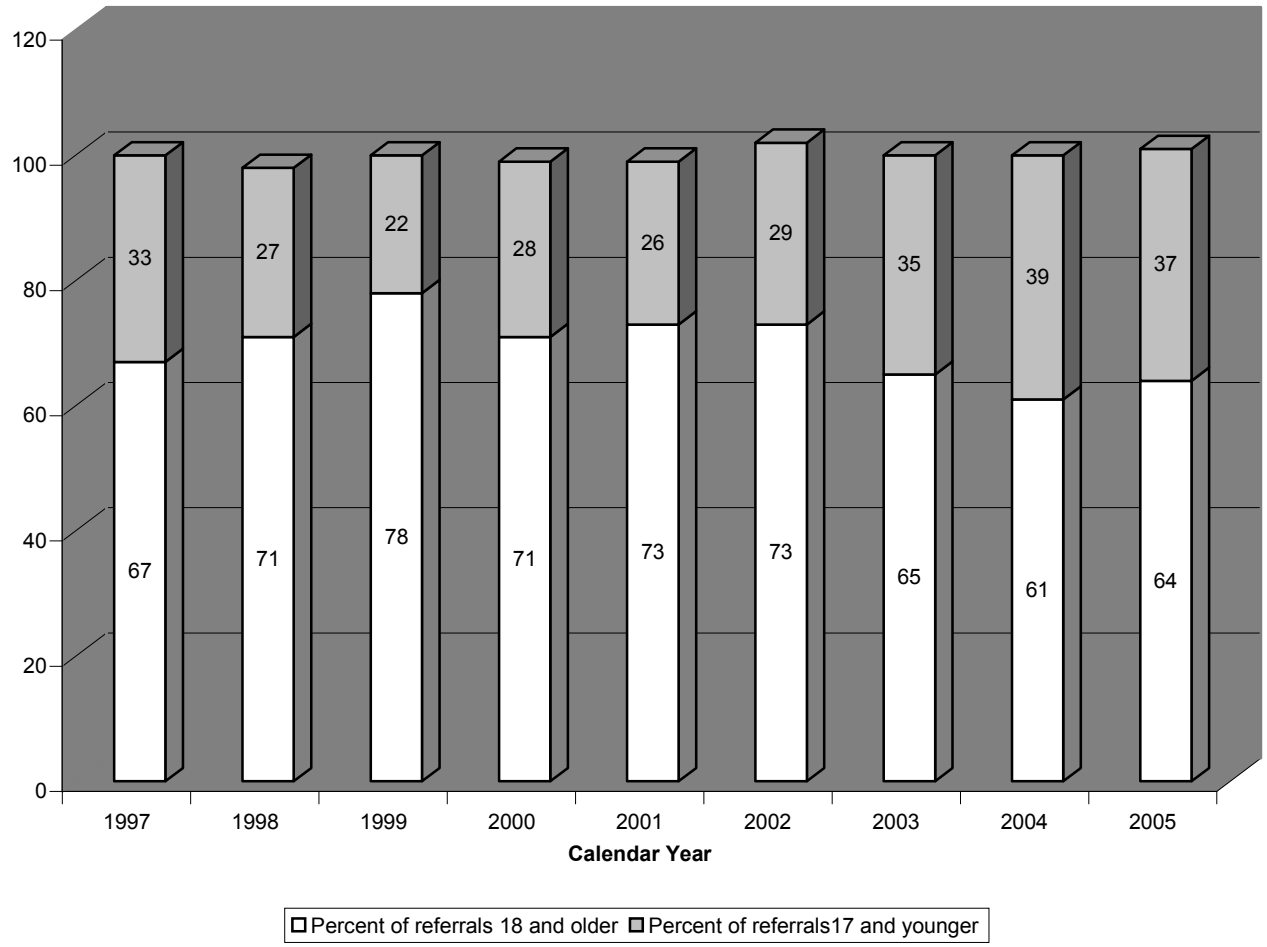
- The clinical complexity of the clients served. For instance, often the mental retardation is co morbid with a mental illness. 61% of MCCP referrals in 2005 had a mental illness diagnosis. Furthermore, In 2005, 4.4 % of referrals had an Axis II diagnosis, though this number is most likely under reported, as the data collection tool does not include an exhaustive list of mental illnesses, including personality disorders. Personality disorders are constituted by personality traits that are inflexible and maladaptive an cause significant impairment or subjective distress. A Personality Disorder can be worsened following the loss of a significant supporting person or previously stabilizing social situations.

- A lack of consistent training in implementing programs that are designed to reduce challenging behaviors. Ongoing training is required to maintain skills. Staff and supervisor turnover is a significant cause.

An increase from last year in emergency referrals could also impact the number of re-referrals. In some cases for a referral made on an emergency basis the interventions to alleviate the crisis situation are greatly diminished. In other words, some emergency referrals can only be remedied by a crisis bed. MCCP and the MRCPG will continue to train caregivers and county social workers in the clinical and financial benefits to referring people to MCCP sooner rather than later.

Emergency versus Preventative Referrals by Year



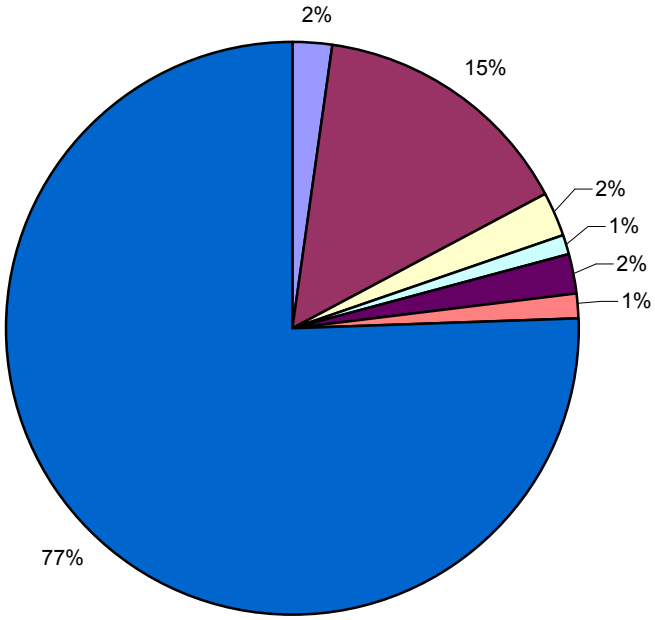


Over the last three years, MCCP has served the highest percentage of clients under 18 in its 9 year history in 2003. Possible explanations could include:

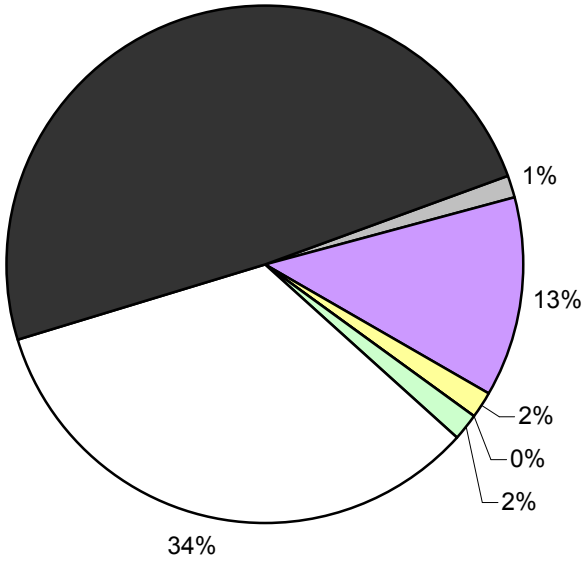
- High number of children and adolescents entering county developmental disability system. In 2005, 45% of child referrals to MCCP had a diagnosis on the autistic spectrum, as did 30% of the adolescent referrals.
- Children and adolescents entering the county developmental disability and related conditions system already in crisis.

Additional causes could be due to the Increases in parental co-pays which may have resulted in reduction of services, and a possible subsequent decrease in preventative efforts by professionals.

2002-2004 Racial Data



2005 Racial Data



The vast majority of clients that MCCP served in 2002-2004 and 2005 have been white, with black being the second largest population served. According to the data , MCCP served a profile that is similar to that of the United States as a whole. However, though Black or African Americans are over represented in MCCP's 2003 service profile, persons Hispanic or Latino origin are underrepresented. In order to facilitate persons of Hispanic or Latino origin utilizing crisis services, in 2003, several important service documents were translated into Spanish, and MCCP has one Spanish speaking person on staff. Additionally, MCCP also receives cultural sensitivity and orientation training.

	MCCP		Minneapolis/St. Paul Urbanized Area (pop. 2,388,593)	Minnesota*	USA*
	2002-2004	2005			
White persons, percent	77	48	83.4	89.4	75.1
Black or African American persons, percent	15	13	6.4	3.5	12.3
American Indian and Alaska Native persons, percent	1	0	1	1.1	0.9
Asian, Native Hawaiian and Other Pacific Islander persons, percent	2	1	5	2.9	3.7
Persons of Hispanic or Latino origin, percent	2	2	3.8	2.9	12.5

MCCP collects data on race and ethnicity on interviews with the client and/or caregivers. However, MCCP is not always in a position nor is requested by the member Counties to see each and every client, such as in the case of Information and Referral services. Therefore, a certain percentage of MCCP clients are classified as unknown as to race or ethnic identification.

*Source: Minnesota QuickFacts from US Census Bureau

Information and Referral Data

MCCP prioritizes the utilization of Crisis and Temporary Care Beds throughout the seven metro county area. MCCP also prioritizes the utilization of Staff Augmentation Services available in the metro area. Upon prioritizing the utilization of these resources MCCP's Information and Referral Specialist makes a referral to the vendor selected to provide the service. Most cases which are strictly I & R (e.g.: cases which do not include TA) are relatively short in duration. As such, MCCP does not seek reimbursement for straight I & R cases which do not exceed 10 units of service.

Prioritization Considerations For Crisis & Temporary Care Beds

1. *Risk factor analysis:*
   a. *Risk of loosing placement? (or being hospitalized)*
   b. *Risk of being harmed in current placement?*
   c. *Risk of harming self?*
   d. *Risk of harming others?*

2. *Goals of placement.*
   a. *Get person out of abusive environment?*
   b. *Avoid hospitalization?*
   c. *Avoid RTC placement?*
   d. *Behavioral/Psychiatric Stabilization?*
   e. *Medication Stabilization?*
   f. *Assessment and Recommendations?*

3. *Match client need with service that is available?*
   a. *Can available bed meet the persons need? (e.g.: environmentally; programmatically)*
   b. *Is it the least restrictive setting?*
   c. *Is it close to the person's natural environment?*
   d. *What are the issues with the other people at that setting?*

4. *Additional Considerations*
   a. *Projected length of stay?*
   b. *Housing in home County is preferential.*
   c. *Limiting the potential number of transitions is preferential.*
   d. *Maintaining day program, school, or work placements are preferential.*

The large jump in the percentage of I & R cases is a result of several factors:

- Commitment of MCCP to begin implementing certain functions of the Managing Entity project, namely, attendance at crisis home meetings. MCCP attends intake, 15 day, 30 day, and 45 day meetings at the crisis homes.
- Crisis Bed capacity doubled when the stay limit went from 90 days to 45 days. Therefore, more people have used the beds.
- MCCP has found that when preventative referrals are very low bed demand remains consistent. Demand for beds has also been very high at times.

- Children beds have a low percentage of empty bed days. Meridian, which opened for business on March 1, 2005, has demonstrated an ability to serve a diverse population and a variety of differing needs.

Meridian Crisis Home

- *Clients served in 2005:* **24**
- *Average Length of Stay:* **43.3**
- *Occupancy Rate:* **82%**

► Occupancy at adult beds can ebb and flow. Minnesota State Operated Community Services (MSOCS) took over the Minnehaha and Dakota Crisis Homes in the summer of 2005; MSOCS inherited the homes from Eastern Minnesota. Services have changed at Minnehaha and Dakota, as MSOCS now offers the possibility of same day admission and a single per diem rate. However, there has been a reduction in behavior analyst staff and services and nursing consult services.

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Minnehaha Crisis Home

Clients served in 2005:

15

Average Length of Stay:

37.80

Occupancy Rate:

77.04%

Other information from Minnehaha Crisis Home:

◊ 567 bed days utilized (736 bed days possible);

◊ Shortest stay: 7 days. Longest stay: 61 days;

◊ 57 days with four beds full; 0 days empty;

◊ Number of days with 1 vacancy: 86; Number of days with 2 vacancies: 40; Number of days with 3 vacancies: 1;

Dakota Crisis Home

Clients served in 2005:

13

Average Length of Stay:

38.38

Occupancy Rate:

67.80%

Other information from Dakota Crisis Home:

◊ 499 bed days utilized (736 bed days possible);

◊ Shortest stay: 7 days; Longest stay: 76 days;

◊ 51 days with four beds full; 0 days empty;

◊ Number of days with 1 vacancy: 61; Number of days with 2 vacancies: 39; Number of days with 3 vacancies: 33;

ICF Crisis and Transition beds continue to be an integral and cost effective service in the metro area crisis system.

► SSP: a four-bed ICF/MR crisis home in Victoria. Handicapped accessible. Nursing staff available.

SSP Crisis Home

Clients served in 2005:
29
Average Length of Stay:
47
Occupancy Rate:
93%

► MORA Transition Unit: four bed ICF/MR Transition/Temporary Care facility in Victoria. Handicap accessible. Nursing staff available.

MORA Transition Home

Clients served in 2005:
14
Average Length of Stay:
88
Occupancy Rate:
84%

People II: a six bed ICF/MR, People II serves dually diagnosed adults in the mild to moderate range of Mental Retardation. The program is run on a mental health model, with groups meeting throughout the day for those clients who do not work or go to school. People II can also serve people with diabetes who require insulin injections.

People Inc., People II

Clients served in 2005:

21

Average Length of Stay:

127

Occupancy Rate:

79.9%

Other Information and Referral Data

The MRCPG has asked MCCP to collect other information regarding information and referral. Specifically, MCCP has been asked to provide information about the length of time that a client must wait for a crisis bed once requested.

On average, 38 days past between a referral being made to MCCP and a request for crisis respite housing. Once the request has been made, a little over one day between the request and prioritization by MCCP, using the prioritization guidelines established by the MRCPG and MCCP. The prioritization is sent within the day to the crisis provider. At this point, the crisis provider can accept or not accept the referral based on their internal considerations (client mix in the crisis home).

The wait between referral to bed and admission is 3.89 days. There are a number of reasons for this delay, including:

- Waiting for the bed to vacate. Referrals to crisis beds have been made before the previous person has left the bed, as this can cut the amount of time it takes to turn the bed. For instance, if a crisis bed vendor knows that a person is leaving in the afternoon, if they have accepted the next referral, that new re-

Category	Number	Percent of Total
Housing forms completed	152	100
Average number of days housing request was made after intake at MCCP	38 Days	
Average number of days between request and prioritization for bed	1.375	
Average number of days between prioritization and referral to bed	.2789	
Average number of days between referral to bed and admission	3.89	
Average number of days between admission and demission	38.7	
Loss of Placement	83	54.6
Harm to Self	87	57.2
Harm towards Others	130	85.5
Harm Towards Property	98	64.47
Harm by Others	38	25.0
Elopement	77	50.65
Undesirable sexual behaviors	29	19.07
Hospital	79	51.9
RTC Placement	11	7.2

ferral could be admitted the next morning. However, Meridian has been able to discharge and admit on the same day.

- Referral may be hospitalized. On occasion, a hospital may not be able to discharge on a the planned day and the transition to the crisis home is delayed..
- A crisis home may delay admission to repair the home.

MCCP will work to lower the number of days between referral to bed and admission. Though some of the factors are out of the control of MCCP, quickening the pace of admission will greatly benefit the crisis system in the metro area. For instance,

- The system will save money by moving people out of hospitals faster. Even a one day reduction in a hospital stay can save significant dollars.
- Reduce stress on families and other caregivers.
- Begin the therapeutic process from returning the client to baseline.

The effort will be a true cooperative effort between counties, MCCP, and crisis providers.

Other Providers in the Crisis System

There are a number of Providers that MCCP does not act as the referring agency but nonetheless impact the metro area crisis system and its capacity.

For instance, many Ramsey County clients are served by Lake Owasso, an ICF/MR that can serve adults that exhibit challenging behaviors. Without the expertise and skill of staff at Lake Owasso, the clients that reside there would be at risk of being high users of the crisis system.

Richfied Crisis Shelter

Clients served in 2005:

28

Length of Stay:

42% between 31 and 90 days

Occupancy Rate:

83%

The Richfield Crisis Shelter and Bloomington Transition Program fill a similar niche in Hennepin County. Both programs serve children and adolescents, with the referrals to the Richfield program coming from St. Joseph's Shelter for Children. Referrals to Bloomington come from individual case managers in Hennepin County.

Bloomington Transition Program

Clients served in 2005:

12

Length of Stay:

38% over 6 months

32% between 91 days and 6 months

Occupancy Rate:

86%

Between January 1995 and December 2005, 54% of the clients at the Richfield Shelter came from Hennepin County Child Protection Division, compared with 46% from the Developmental Disabilities Division. For the Bloomington Program, the breakdown is 43% and 57% respectively.

Appendix I

Metro Crisis Coordination Program (MCCP)
Satisfaction Survey Results
2005

499 Surveys were sent out in 2005. 186 were returned (37%)
Rating scale is 1 to 5 with 5 being very satisfied

Case Managers

175 surveys sent and 80 received (46%)
Overall satisfaction with MCCP services and supports 4.57
Highest satisfaction in ease of referral 4.86
Lowest satisfaction in MCCP's ability to coordinate additional supports and resources 4.11

Families

137 surveys sent and 32 received (23%)
Overall satisfaction with MCCP services and supports 4.68
Highest satisfaction in ability to effectively communicate 4.71
Lowest satisfaction in MCCP's ability to coordinate additional supports and resources 4.44

Residential Programs

96 surveys sent and 35 received (36%)
Overall satisfaction with MCCP services and supports 4.74
Highest satisfaction in effectively communicate 4.91
Lowest satisfaction in MCCP's ability to coordinate additional supports and resources 4.42

Day Programs/Schools

50 surveys sent and 26 received (52%)
Overall satisfaction with MCCP services and supports 4.73
Highest satisfaction in helpfulness of recommendations 4.81
Lowest satisfaction in ease of making a referral 4.58

Other (conservators, hospital, psychologists, etc.)
25 surveys sent and 5 received (25%)
Overall satisfaction with MCCP services and supports 4.80
Highest satisfaction in ease of making referral, response time, communication & coordinate additional resources 5.00
Lowest satisfaction in MCCP's ability to coordinate additional supports and resources & convening recommendations 4.60

Clients (Rating scale is 1 to 3 with 3 being very happy)
16 surveys sent and 8 received (50%)
Most happy with efforts of MCCP to help them, MCCP's ability to explain what MCCP might be able to do to help them & MCCP staff being available to them 3.00
Least happy in MCCP listening to their concerns 2.83

Metro Crisis Coordination Program (MCCP)
Satisfaction Survey Results
2005

Case Managers

MCCP helped develop crisis plan/specific behavioral recommendations 82% (60 of 73)
Plan implemented/cared out 2.31 (1 = not at all 2 = partially 3 = completely)
Any responsibility for carrying out crisis plan/recommendations 38% (23 of 65)
Anticipate need for follow-up support to implement plan 18% yes (11 of 60)

Rating scale is 1 to 5 with 1 being strongly disagree and 5 being strongly agree

MCCP's services resolved the crisis situation 3.63
MCCP's services will prevent future crises 3.49
MCCP's services were clearly explained 4.58
I had enough information to make choices about crisis services 4.62
MCCP's services helped prevent client being removed from living or work situation 81% yes (57 of 70)
Should MCCP's services helped prevent client being removed from living or work situation 77% yes (46 of 60)

Families

MCCP helped develop crisis plan/specific behavioral recommendations 97% (28 of 29)
Plan implemented/cared out 2.73 (1 = not at all 2 = partially 3 = completely)
Any responsibility for carrying out crisis plan/recommendations 70% (19 of 27)
Anticipate need for follow-up support to implement plan 40% yes (10 of 25)

Rating scale is 1 to 5 with 1 being strongly disagree and 5 being strongly agree

MCCP's services resolved the crisis situation 3.83
MCCP's services will prevent future crises 3.60
MCCP's services were clearly explained 4.50
I had enough information to make choices about crisis services 4.30
MCCP's services helped prevent client being removed from living or work situation 96% yes (22 of 23)
Should MCCP's services helped prevent client being removed from living or work situation 86% yes (18 of 21)

Residential Programs

MCCP helped develop crisis plan/specific behavioral recommendations 86% (30 of 35)
Plan implemented/cared out 2.87 (1 = not at all 2 = partially 3 = completely)
Any responsibility for carrying out crisis plan/recommendations 93% (28 of 30)
Anticipate need for follow-up support to implement plan 13% yes (4 of 30)

Rating scale is 1 to 5 with 1 being strongly disagree and 5 being strongly agree
MCCP's services resolved the crisis situation 3.52
MCCP's services will prevent future crises 3.68
MCCP's services were clearly explained 4.34
I had enough information to make choices about crisis services 4.31
MCCP's services helped prevent client being removed from living or work situation 75% yes (20 of 25)
Should MCCP's services helped prevent client being removed from living or work situation 76% yes (24 of 32)

Day Programs/Schools

MCCP helped develop crisis plan/specific behavioral recommendations 96% (24 of 25)
Plan implemented/cared out 2.75 (1 = not at all 2 = partially 3 = completely)
Any responsibility for carrying out crisis plan/recommendations 96% (24 of 25)
Anticipate need for follow-up support to implement plan 12% yes (3 of 25)

Rating scale is 1 to 5 with 1 being strongly disagree and 5 being strongly agree
MCCP's services resolved the crisis situation 4.14
MCCP's services will prevent future crises 3.95
MCCP's services were clearly explained 4.64
I had enough information to make choices about crisis services 4.60
MCCP's services helped prevent client being removed from living or work situation 88% yes (21 of 24)
Should MCCP's services helped prevent client being removed from living or work situation 67% yes (12 of 18)

Other (conservators, hospital, psychologists, etc.)
MCCP helped develop crisis plan/specific behavioral recommendations 100% (4 of 4)
Plan implemented/cared out 2.67 (1 = not at all 2 = partially 3 = completely)
Any responsibility for carrying out crisis plan/recommendations 80% (4 of 5)
Anticipate need for follow-up support to implement plan 20% yes (1 of 5)

Rating scale is 1 to 5 with 1 being strongly disagree and 5 being strongly agree
MCCP's services resolved the crisis situation 4.00
MCCP's services will prevent future crises 3.60
MCCP's services were clearly explained 4.60
I had enough information to make choices about crisis services 4.60
MCCP's services helped prevent client being removed from living or work situation 80% yes (4 of 5)
Should MCCP's services helped prevent client being removed from living or work situation 60% yes (3 of 5)

Appendix II

Pooling Allocation Proposal in Brief

MCCP, the coordinating agency for the seven metro counties, proposed a two-phase plan to overhaul the crisis system for people with developmental disabilities in line with the seven metro counties best practice and service provision criteria. The seven metro counties agreed to the two-step format. It was amended in December 2005 to include an additional step.

In Phase I, the primary function of MCCP was to act as the Managing Entity/Administrative Service Organization. The primary objective of this phase was to continue to provide existing services, gather information, and to work with providers in the system to begin to achieve savings.

In Phase II, MCCP will operate as the administrator of a crisis system that provides the counties with a more consistent cost for crisis services. In this phase, MCCP will be contracting with providers and paying them directly for services rendered.

Phase I (July 2004-18+ Month Duration)

MCCP acted as a Managing Entity/Administrative Service Organization for the seven metro counties. MCCP, on behalf of member counties, provided the following services specific to this proposal:

1. Continued to provide its crisis services per contract and general practice;
2. Determined service limits, outcomes, and costs of all crisis providers, including EMCSS.
    a. Gather Data.
        i. Worked with all crisis providers including EMCSS to ascertain service and cost standards, enhance MCCP data collection capability, and report to Steering Committee.
    b. Outcome: Data determined what services are typically used and for how long. The seven metro counties and MCCP determined the size of the crisis system, in dollars, that would be funded by the counties. This crisis system is expected to serve current and future clients at

the same level of service as in the past.

3. Management of crisis dollars.
    a. Acted on behalf of counties to efficiently and effectively use their dollars for crisis billing codes (X5685, X5665,and X5664).
        i. Negotiated with EMCSS-rates, services.
        ii. Negotiated with State/DHS.
        iii. Negotiated with all crisis service vendors' rates for any and all services.
    b. Outcome: The management of crisis utilization and costs are key to the success of both Phase I and Phase II. In Phase I, MCCP and members of the MRCPG neogitated a single rate for state run crisis homes. Additionally, MCCP worked to develop services for one children's crisis home, opened in March of 2005, and a children's transition home, opening in early 2006.
4. Reported to counties progress and updates at regular intervals.

County	*Allocation*	*% of Total*
Anoka	$300,000	6.5
Carver	60,000	1.3
Dakota	430,000	9.3
Hennepin	2,800,000	60.8
Ramsey	650,000	14
Scott	160,000	3.5
Washington	200,000	4.3
	$4,600,000	**100%**

Phase II (First Quarter, 2006)

This Phase was added in December of 2005. In the first quarter of 2006, a managed care system will be defined based on the information and practices developed in Phase I and the decision of the MRCPG and the Minnesota Department of Human Services to change from a prepaid capitation system to a guaranteed county annual payment for aggregate services rendered. MCCP service rates will be modified and annual services that will be provided shall be defined in the host county contract with Hennepin County.

Key elements in this system include:

- Annual county dollar commitments;

- $150 co-pay for crisis beds, based on county average crisis bed use, is included in county dollar commitment.

- MCCP profit and loss risk corridor;
  - 2%/1%
- Approval from seven county Administrative Group for any increase in the total MCCP budget;
- Approval from seven county Steering Committee (MRCPG) for any decrease in maintenance of effort by MCCP or any/all of the member counties if it impacts system capacity.

Phase III (Implementation Date: April 1, 2006)

1. Implement system of providing crisis services to people with developmental disabilities and related conditions.
   a. Member counties and MCCP will negotiate a yearly contribution. This contribution was based on first agreeing on the size of the crisis system to be funded, as well as the past usage of the system by each county. Each county share may be adjusted in future years.
   b. Hennepin County will hold the contract with MCCP and MCCP will contract with Crisis Providers in the region. MCCP will pay providers for services rendered in the crisis system
   c. MCCP and member counties will develop a risk corridor. A risk corridor is a mechanism for limiting any losses by MCCP and member counties.
      i. The corridor will be centered on a target point, typically the total amount of annual contributions.
      ii. Over or under spending within a given percentage above or below that targeted point are assumed by MCCP.
      iii. Member counties and MCCP could share over or under spending beyond the established risk corridor.

Outcome: MCCP will provide necessary services and outcomes for all eligible clients. In the seven metro counties, as of January 1, 2005, there are about 14,306 people with Mental Retardation/Related Conditions receiving case management, or about 52% of the entire state population of people with Mental Retardation/ Related Conditions.