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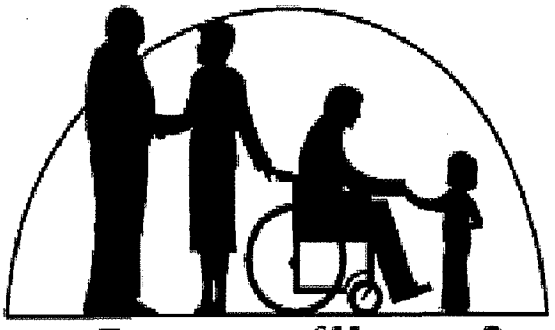
Study of Services Provided by State Operated Services to Persons with Developmental Disabilities Who Have Complex Care Needs

State Operated Services Report
to the
2004 Legislature

January 2004

Mandated by Minnesota Session Laws, Special Session, 2003,
Chapter 14, Article 6, Section 63



Minnesota Department of **Human Services**

Study of Services Provided by State Operated Services to Persons with Developmental Disabilities Who Have Complex Care Needs: State Operated Services Report to the 2004 Legislature

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I. EXECUTIVE SUMMARY

During the 2003 session, The Minnesota State Legislature directed the Department of Human Services (DHS) to study selected aspects of services provided to persons with developmental disabilities who have complex needs. Criteria for the study, as established by the Legislature, requested DHS to review and consider the service needs of this population; methods of providing services to them; the costs and cost-effectiveness of providing such services; defining the factors that encourage and inhibit service vendors; alternative populations that could be served by State Operated Services (SOS) residential facilities; and the population served and cost-effectiveness of services provided by SOS's Minnesota Extended Treatment Options (METO) program.

This report begins by setting forth clarifying definitions of the terms "developmental disabilities" and "complex care needs", and then proceeds to address and respond to the study criteria, delineated by the Legislature, with the exception of addressing the request that DHS examine the costs and cost-effectiveness of providing services to consumers with developmental disabilities.

Insofar as Minnesota currently has in place a county driven system of planning, developing, contracting, and paying for services to individuals with developmental disabilities, the limited time parameters allowed for completing this study did not allow for an appropriately designed, objective, comprehensive study of issues surrounding costs and cost-effectiveness. In order to be appropriately responsive to this part of the Legislature's request, SOS has secured the commitment of the Research and Training Center on Community Living, Institute on Community Integration at the University of Minnesota to undertake this part of the study. In so doing, SOS commits itself to utilizing funds set aside for this study in the 2003 Legislative session for this purpose. SOS is, therefore, requesting Legislative approval to extend the date for this part of the report to January 15, 2005.

II. INTRODUCTION

During the 2003 Session, the Minnesota State Legislature adopted the criteria that required the Department of Human Services (DHS) to study services provided to persons with development disabilities who have complex care needs. These criteria were specifically outlined in the following Session law.

> *The commissioner of human services shall study the services provided to persons with developmental disabilities who have complex care needs. The commissioner shall analyze:*
>
> *(1) the needs of the target population;*
> *(2) the methods of providing services to the target population;*
> *(3) the costs and cost-effectiveness of providing services to the target population;*
> *(4) factors that encourage and inhibit vendors, including state-operated community services (SOCS), to provide services to the target population;*
> *(5) alternative populations that could be served by state-operated residential facilities; and*
> *(6) the population served by Minnesota extended treatment options and the cost-effectiveness of these services.*
>
> *The commissioner shall report on the results of the study under this section to the chairs of the house and senate committees with jurisdiction over state-operated services by January 15, 2004.*
>
> Minnesota Session Laws, Special Session, 2003, Chapter 14, Article 6, Sec. 63.

Definitions.
The term "developmental disabilities" is defined in the Minnesota Disabilities Services Program Manual as:

> "A severe, chronic disability attributable to mental and/or physical impairment, which manifests before age 22 and is likely to continue indefinitely. The disability results in substantial limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency, as well as the continuous need for individually planned and coordinated services."

The term "complex care needs" is used to denote individuals that have overriding medical and behavioral complexities that are atypical of other individuals receiving supports, which then require additional staffing, and support capabilities on the part of provider.

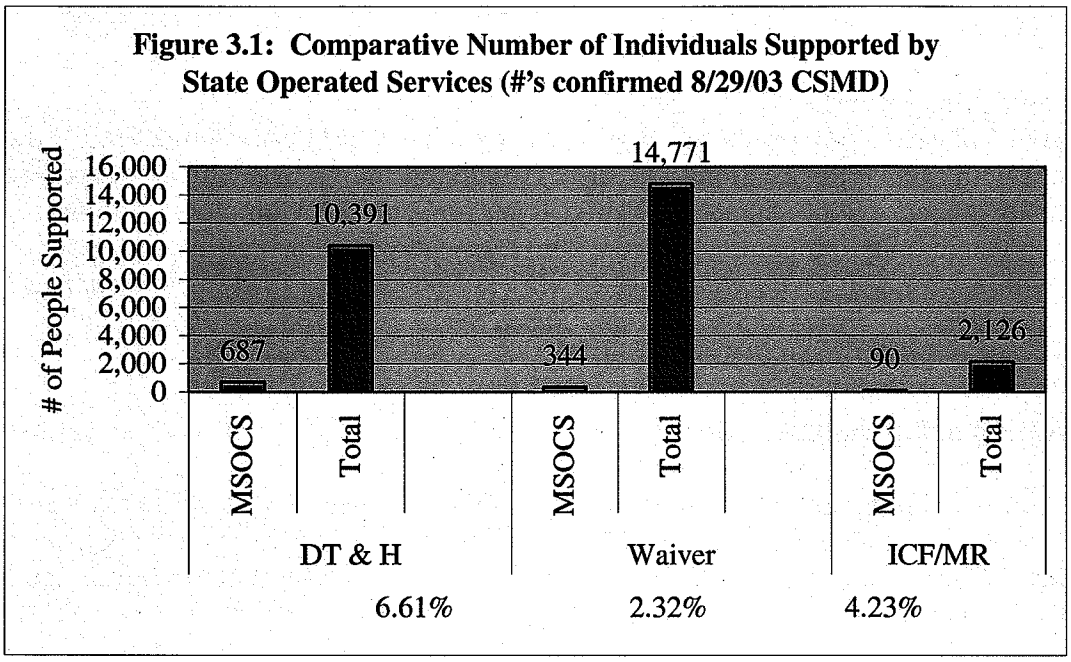
III. STATE OPERATED COMMUNITY SERVICES (SOCS)

History and Background.
The State of Minnesota previously relied primarily on the use of Intermediate Care Facilities for persons with Mental Retardation (ICF's/MR) to support individuals with complex care needs. In November of 2000, the Research and Training Center on Community Living--Institute on Community Integration from the University of Minnesota released a report entitled *"An Independent Evaluation of the Quality of Services and System Performance of Minnesota's Medicaid Home and Community Based Services (HCBS) for Persons with Mental Retardation and Related Conditions."*

A key finding was that:

> "the HCBS program in Minnesota now supports more people with serious or very serious challenging behavior and a higher proportion of such individuals than the ICF/MR program. However, people with more severe intellectual disabilities are less likely to have access to HCBS than are people with less severe intellectual disabilities. Possible reasons for this include concern about the higher expense of supporting individuals with more extensive support needs while maintaining the total cost of services under a county's allowable total expenditures. In 1995, an effort was made to address this concern with the implementation of the Wavier Allocation Structure. Yet five years after the change, persons with severe or profound intellectual disabilities are still proportionally less likely to receive HCBS funded supports."

Currently, Minnesota State Operated Community Services (MSOCS) supports 6.61% of individuals supported in Day Training & Habilitation (DT & H) services, 2.32% of Medicaid Waiver Recipients, and 4.23% of individuals residing in ICF's/MR. Figure 3.1 illustrates participant numbers as supported by data from a report dated 8/29/03 distributed by the DHS Community Supports for Minnesotans with Disabilities Division.



Needs of the Target Population.
Individuals with developmental disabilities who have complex care needs typically require multiple levels of support in several areas. These include supporting:

- Acute illness-short in duration yet exacerbates care needs in other areas;
- Serious ongoing illness-a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve continuous months or more;
- Addictions-including chemical dependency;
- Aging processes which may coincide with illnesses as listed above, or diminishing intellectual capacities and physical capabilities;
- Behavioral needs-psychotropic medications, support plans, crises intervention/wrap around support;
- Physical limitations-hearing, speech, vision, mobility, eating disorders/special needs, toileting, and other activities of daily living.
- Complications resulting from a traumatic brain injury or a persistent mental illness.

In and of themselves, any one condition can bring about the need for developing specialized supports. When paired with multiple conditions (complex needs), this brings additional challenges for the support provider.

Methods of Providing Services.
Minnesota originally developed a system in which supports were designed by the individual, their family and the county case manager. A Request for Proposal was sent to potential providers. The individual, family and case manager would then select a provider based on the programmatic strength and budget submitted by the provider. In reality, supports are often dictated by "fitting into" the opening held by a provider on any given day.

The State of Minnesota is highly reliant on a congregate care model utilizing shift staff to provide necessary supports to this population. Cost constraints have made it difficult to individualize supports in other types of models. Going forward, more emphasis needs to be placed on the development and funding of services using natural supports. Typically, individuals with complex care needs bounce from provider to provider, requiring hospitalization or the intervention of a Crisis Service provider to fill the gaps. Traditional supports are:

- Supervised Living Services
- Intermediate Care Facilities for Persons with Mental Retardation (ICF's/MR)
- Day Training and Habilitation Services
- Semi Independent Living Services
- In Home Family Support
- Crisis Intervention Services

Costs and Cost-Effectiveness of Providing Services.
The limited time parameters allowed for completing this study have not been sufficient to undertake an objective comprehensive study of the cost and cost-effectiveness of providing services and supports to this target population as requested in the legislation requiring this report. Currently, Minnesota has a county-driven system of planning, developing, contracting and paying for services to individuals with developmental disabilities. To be appropriately responsive to the request for cost and cost-effectiveness information, SOS intends to contract with the Research and Training Center on Community Living, Institute on Community Integration at the University of Minnesota to study and report on the following subset of questions:

- How do counties determine that an individual is high-risk or has "complex needs?"
- How are financial resources for services allocated?
- What is the process used by counties to select vendors?
- Does it allow equal access to the competitive market?
- How do counties decide on a vendor?
- If vendors feel they have been treated unfairly, what recourse do they have to resolve concerns?
- What are counties willing to pay for services provided to individuals with complex needs?
- Current costs (rates) for services, and the cost-effectiveness of services delivered across counties

Factors That Encourage and Inhibit Vendors to Provide Services.

Factors that Encourage	Factors that Inhibit
• Mission of the organization	• Affordable housing
• Funding Stability	• Up front time lost if not awarded the contract
• Desire to be of support/assistance	• Difficulty hiring

	competent/experienced staff to support individuals with complex care needs
• Expands business opportunities	• Public Relations issues
	• Limitations on $ available
	• Compatibility of individuals living together-difficult at best
	• Limited back up/support if something goes wrong when supporting individuals with complex care needs

Alternative Populations That Could Be Served by SOCS Residential Facilities
The current State policy is for SOCS to respond only to requests to develop new services when the payee, individual/guardian/family are unable to secure a viable alternative provider.

IV. MINNESOTA EXTENDED TREATMENT OPTIONS (METO)

History and Background.
As in most states, as funding for private ICF/MR development became more available in the 1960's, Minnesota began the long process of "deinstitutionalizing" its services for individuals with developmental disabilities. In 1980, a lawsuit brought in federal court resulted in the Welsch Consent Decree in which the State of Minnesota agreed to further downsize its state institutions serving persons with developmental disabilities. In 1983, the Home and Community Based Services Title XIX Waiver option became available in Minnesota to expand funding and service options available for persons with a developmental disability for being served in the community. In 1987, Minnesota reached an agreement with its state employee bargaining units to develop State Operated Community Services (SOCS) to help offset the loss of state employee jobs as the state institutions continued to downsize and close. As a result State Operated Community Services were developed to provide residential and day training services to approximately 850 individuals (represents 3.6% of the 23,310 receiving services) with mental retardation or a related condition. In 1989, Minnesota began providing Community Support Services (CSS). CSS now has community support teams operating in all regions of the state to provide crisis respite, staff augmentation, and a variety of consultation services for this population.

In 1995, planning began to occur in earnest around the eventual closure of Cambridge Regional Human Services Center. A Community Task Force was formed with representation from counties, the City of Cambridge, bargaining units and treatment staff. There was broad consensus for the development of a specialized program for individuals who are court committed to "the State" based on risk to themselves and the community with the objective of safely returning them to the community as soon as possible. The recommendations of this task force resulted in legislation creating the METO program (Minnesota Laws 1997, Chapter 203, Article 1, Section 2, Subdivision 7).

Minnesota's Model.
Minnesota is somewhat unique in its services to persons with developmental disabilities. Minnesota is one of the largest states to have eliminated its large institutions for persons with developmental disabilities. Services are generally available throughout our communities and the vast majority of individuals with developmental disabilities are now successfully supported in community living. Some individuals, however, present significant challenges even to the best community service systems. This is particularly the case when the circumstances or condition of the person changes. As a result, Minnesota has chosen to create a system of specialized services. This system of specialized services consists of CSS, crisis services, and the Minnesota Extended Treatment Options Program. Crisis service vendors include both CSS and private vendors.

To understand the role of these specialized services, it must be appreciated that there are a number of individuals living in the community, who at any point in time, might experience significant behavioral, psychiatric, and/or health issues. In most cases, the changing needs of these individuals can be addressed through the provision of additional, sometimes specialized, and often temporary services (specialized nursing, behavioral consultation, psychiatric

consultation) to the person in their current place of residence. Home and Community Based (HCBS) Waiver funding provides for this option with specialized technical support and staff augmentation services available through crisis services. In other cases, the individual must be moved elsewhere to meet their current needs. Sometimes the individual in crisis may need to actually go somewhere else but only for a brief period of time until additional resources and training can be developed and provided. Minnesota meets the need for behavioral crisis by providing special crisis beds (both state and privately operated) that are funded through the HCBS Waiver. Finally, for a small number of individuals (.6% of the 26,076 individuals with developmental disabilities in Minnesota), who cannot be safely served in these less intrusive ways, it is necessary to provide a very specialized residential service. METO currently serves this specialized role in Minnesota while other states rely on utilizing long-term psychiatric hospitals beds.

An important thing to understand in this model is that there is not a fixed group of individuals served in crisis services or METO. The individuals in need of these services are always changing. If these specialized services are working correctly, then individuals who receive them will eventually no longer need them and will be successfully transitioned back into Minnesota's larger and more generic community service system. An important concept in this model is that the individuals themselves may still be difficult to serve after leaving the specialized services. Most behavioral crises are the result of mismatches between the supports and services an individual receives and the supports and services the person needs. What has changed is our understanding of the person's needs and as a result, our ability to better tailor the supports and services the individual receives.

General Program Description.
The Minnesota Extended Treatment Options (METO) program is a specialized service designed to meet the needs of those individuals with developmental disabilities whose behavior or actions present a risk to public safety. With outreach and support services available through CSS, admission to the specialized residential program can be limited to those few individuals who exhibit such extreme behaviors that they cannot at present be served safely in their communities. The METO program employs a variety of service methods including behavior programming and therapy, individual psychotherapy and counseling, small group instruction and counseling, and psychiatric assessment and follow up. Treatment and service planning takes a person-centered approach and, to the extent possible, treatment modalities are integrated in their delivery. The METO specialized residential program works closely with the responsible county to return the individual to the community as soon as necessary supports are available to ensure public safety. In some cases, initial assessment may lead to the identification of necessary supports and services that can be readily put into place and result in a rapid return of the individual to the community. In other cases, the individual will not be able to return safely to the community until substantial treatment is completed and/or until substantial planning and modification of community services and supports has occurred.

Vocational Services: METO provides self-contained vocational and day program services in conjunction with the specialized residential beds. Opportunities for work are provided through three avenues - traditional contract production (piece) work, work crew contracts with

community agencies (e.g., clean local ice arena, cut grass for CSS crisis homes), and facility maintenance and support work.

Recreational Services: METO has a newly remodeled recreation building and employs two recreation therapists. It provides an aggressive recreation program for its clients with high participation in Special Olympics and a focus on the development of small group and individual leisure skills.

Health Care: General medical and psychiatric services are provided on site. Nursing services are present 24-hours per day, seven days per week. Ancillary health care services (e.g., physical therapy, occupational therapy, speech/language services, Audiology services, neuropsychological services, dental services, and pharmacy services), specialized diagnostic services (e.g., X-ray, lab, EEG), and medical specialties are arranged through outside agencies.

Treatment Services:
The presenting problems of the clients referred to METO are complex. Successful restoration of the METO client to community living requires a thorough understanding of the nature of the client's behavior and an equally thorough understanding of the client's community and the settings in which the client will participate. Consequently, the overall intervention strategy focuses on closing the gap between the client's behavioral competence and the community's capacity to provide supports. The treatment program itself operates on a psychosocial treatment model that focuses on teaching the client the skills necessary to become socially effective within the community to which he or she is expected to return. The community's capacity is addressed through on site review of the planned placement site and coordination with the case manager and selected provider to address identified issues prior to a client's discharge

Mental health treatment: Approximately 35% of the individuals admitted to the METO on-campus program have significant mental health issues. At any point in time, 80% - 100% of the clients living at METO have a psychiatric diagnosis. Treatment modalities include individual psychotherapy and counseling, psychiatric assessment and follow up, and psychotropic medication evaluation and adjustment.

Aggressive/assaultive and other challenging behavior: Over half the individuals served in the METO program have a history of serious aggressive or assaultive behavior. Behavior management/therapy has proven to be a powerful tool in the treatment of individuals with mental retardation who manifest significant behavioral challenges. A key component in addressing the challenging behaviors of all METO clients is the completion of a functional analysis of challenging behaviors in order to guide the treatment team's selection of intervention strategies.

Treatment for individuals who have committed criminal offenses: METO does not serve individuals who are under the authority of the Department of Corrections. The METO program, however, is expected to serve individuals who have demonstrated assaultive and/or sexually inappropriate behavior, which may have resulted in criminal charges. Treatment

modalities focus on teaching alternatives to aggression, enhancing self-concept, and learning to accept personal responsibility. The treatment component addressing sexually inappropriate behavior is integrated into the individualized treatment plan.

Rule 20.1 subdivision 5, treat to competency: METO provides a structured assessment process in cases where clients are committed to METO under Minnesota Rules of Criminal Procedures 20.01, Subd. 5, with a charge to "treat to competency." In some cases, METO coordinates with SOS Forensic services to perform initial competency evaluations as specified in Minnesota Rules of Criminal Procedure, 20.01, Subd 2, particularly in cases where it is suspected that an individual's competency may be affected as the result of mental retardation. Individuals who are determined to be in need of secure settings are transferred to the Minnesota Security Hospital at St. Peter.

Treatment and support for victims of sexual abuse: It is estimated that over half the female clients and a somewhat smaller percentage of male clients of METO have experienced some form of sexual abuse. Such experiences often result in extreme anger and hostility or perpetration of similar offenses against others. Consequently, the METO program provides counseling and support for those individuals who have been victims of sexual abuse.

Treatment for substance abuse: METO is not a chemical dependency treatment program. However, because between 10% and 20% of METO clients have a history of chemical dependency or substance abuse, METO does provide a modified curriculum to address these issues. The primary focus is on determining those factors most likely to contribute to the individual's chemical use so these factors can be monitored and controlled when the individual returns to the community.

Transition services: The individuals who are admitted to METO come from the community and are expected to return to the community. The flexible funding provided by Minnesota's Home and Community Based Services Waiver (as well as other waivers such as CADI and TBI) permits community services to be designed around the individual. Similarly, transition supports are unique to each individual based on the needs of that individual and the needs of their prospective community provider. As part of transition and follow-up services, METO staff are prepared to assist the county case manager in identifying the necessary characteristics of the services and supports required by individuals leaving the specialized residential program, assist the selected community provider to prepare for the client, provide staff training specific to the needs of the client, augment direct support staff during critical transition periods, help identify potential problem areas and ways to address them, provide consultation as required and monitor the client throughout the provisional discharge period. As with outreach services, METO can coordinate transition services with Regional CSS Teams to further its ability to provide transition services regardless of where the individual is placed within the state.

Outreach Services: When provided with appropriate services and supports, most individuals with challenging behaviors, including those who initially appear to present a risk to public safety, can be maintained in a community setting. The METO target population is a subset of the larger target population served by state-operated, regionally-based Community Support

Services that serve individuals who are developmentally disabled and at risk of being displaced from their communities. METO coordinates its outreach and support services with regional-based CSS teams. These regional CSS teams provide a package of services including expert consultation, on-site evaluation, direct service support, and crisis services with the goal of preventing the unnecessary removal of individuals from their community. The services of CSS are not limited to individuals who present a risk to the public but such individuals constitute a subset of the larger target group served by CSS. Through coordination with CSS it is hoped that most individuals with challenging behaviors, including those who initially appear to present a risk to public safety, can be maintained in the community through the provision of appropriate services and supports.

Admission Criteria and Process.

Admission Criteria: To meet METO admission criteria an individual must:

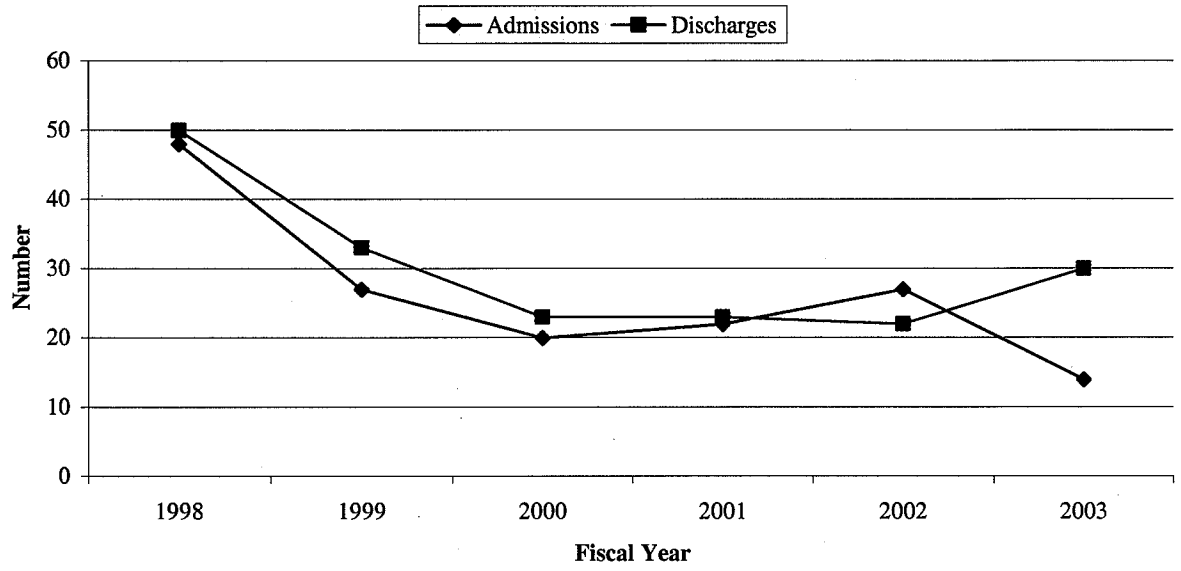
a. be a least 18 years of age;
b. have mental retardation or a related condition in accordance with Minnesota Rules, part 9525.0016, subdivision 2;
c. be under an appropriate legal status identified in Minnesota Statute, 253B (the Minnesota Commitment and Treatment Act) or Minnesota Rules of Criminal Procedure 20.01 or 20.02;
d. exhibit behavior or actions that present a risk to public safety and cannot be safely managed with currently available community supports; and
e. have a documented need for active treatment that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services in activities of daily living (ICF/MR eligibility requirement)..

Admission Review Committee: The METO Admission Review Committee is currently composed of the METO Admissions Officer, the METO Clinical Director and a psychiatrist representing State Operated Services. The METO Admissions Review Committee must review every referral to METO. Referrals must come from the responsible county. In addition CSS is asked to screen each referral and submit a brief report and recommendation to the Admission Review Committee in support or opposition to admission. The Committee reviews admission requests to ensure appropriateness of admission. Factors considered in addition to the above specified admission criteria include:

a. preferences of the person and person's guardian or family;
b. ability of METO to safely meet the person's need;
c. safety issues such as vulnerability of family, roommates, and staff;
d. previous community based treatment; and
e. need for ICF/MR level of care.

When an individual referred to METO is civilly committed to the Commissioner of DHS under the Minnesota Commitment and Treatment Act and the METO Admissions Review Committee determines the individual either does not meet all the METO admission criteria or the program cannot safely serve the individual, the case is referred to the SOS Chief Executive Officer for a final decision on where the individual is to be served.

Figure 4.1
METO Admissions and Discharges



Who Is Served In The METO Program?

The following information is summarized for the 6-year period 7/1/97 – 6/30/03 (FY 98 – FY 03).

Their Demographics:

There were a total of 158 admissions to the METO program during the 6-year period 7/1/97-6/30/03 (see Figure 1). Of these, 74.05% were male, 25.95% female, for a male to female admission ratio of 3:1. The average age was 30.1 years. Minorities constituted 29.75% of total admissions. Approximately 83% were on psychotropic medications at admission. In terms of level of cognitive disability, 80.38% were mildly retarded, 13.29% were moderately retarded, 4.43% were not considered retarded, and only 1.9% were severely or profoundly retarded.

Where Do They Come From?

METO admissions come from a variety of different living situations including 37.9% from Corporate Waiver sites, 5.7% from community ICF/MR, 19% from family homes (some with and some without extensive support services), 10% from Mental Health Units of other Regional Treatment Centers. (See Figure 4.2 for a more complete list of living arrangements prior to METO admission.) During the 5-year period, METO has admitted clients from 42 different counties. Nearly 36% of METO admissions have come from Hennepin County and nearly 60% from the 7-county metro area. Over 30% are originally admitted to a community psychiatric unit in response to their behavioral issues before they come to METO and 37.34% have had significant involvement of CSS prior to admission.

Figure 4.2: Residential Site Prior To Admission	N	Percentage
Home Immediate Family	19	12.03%
Home Extended Family	1	0.63%
Foster Family	3	1.90%
Foster Corporate	60	37.97%
Own Home with 24-Hr Supervision	11	6.96%
Own Home with less than 24-hr Supervision	6	3.80%
ICF/MR Community	9	5.70%
ICF/MR RTC	0	0.00%
Nursing Facility	1	0.63%
Board and Care	0	0.00%
Community Mental Health Facility	2	1.27%
Mental Health - Adolescent	0	0.00%
Other	30	18.99%
RTC Mental Health Unit	16	10.13%
Total	158	100.00%

What Are Their Referral Problems?

METO tracks up to five reasons why a person is referred. The seven most frequent reasons cited are - *physical aggression* (62.58%), *sexual acting out/ inappropriate sexual behavior* (22.58%), *property destruction* (21.29%), *non-compliance* (14.84%), *sexual assault of a minor* (13.55%), *suicide gesture/threat* (12.26%), *and self-injurious behavior* (11.61%). Just over 13% are admitted under Rule 20 with treat to competency requirements. (See Figure 4.3 for a more complete listing of reasons for admission.) Nearly all admissions were civilly committed. This means a District Court determined that the individual presented a risk to self or others and no appropriate alternative placement site was available. Only 4 admissions, all during FY 98, were voluntary and they were the result of conditions of probation. Since the publishing of formal METO admission criteria in 1999, no admissions to METO have been voluntary.

Figure 4.3

Reason For Admission*	Fiscal Year 98	99	00	01	02	03	TOTAL	Percent
(n)	*48*	*27*	*20*	*22*	*27*	*14*	*158*	**Admits**
Physical Aggression/Assault	23	16	15	15	18	10	97	61.39%
Attempted Murder	0	0	0	0	0	0	0	0.00%
Threat to others with weapon	3	1	0	3	2	1	10	6.33%
Threat to others without weapon	5	1	0	0	4	2	12	7.59%
Rule 20 - Treat to competency	6	2	1	2	2	1	14	8.86%
Rule 20 -								
Not guilty by mental deficiency	0	0	0	2	0	0	2	1.27%
Dangerous (to others) behavior	0	4	2	6	0	2	14	8.86%
Sexual assault of adult	1	1	1	0	0	0	3	1.90%
Sexual assault of minor	7	3	3	5	2	1	21	13.29%
Sexual acting out								
Inappropriate sexual behav.	3	9	7	4	7	5	35	22.15%
Property destruction	7	4	4	5	8	5	33	20.89%
Fire setting	1	0	1	1	2	1	6	3.80%
Criminal theft	1	1	2	0	1	0	5	3.16%
Elopement	6	1	3	5	8	2	25	15.82%
Non-compliance	6	4	3	0	8	2	23	14.56%
Nuisance/obnoxious behavior	0	0	0	2	0	0	2	1.27%
Socially unacceptable								
Offensive disruptive behav.	5	1	1	2	3	1	13	8.23%
Self-injurious behavior	2	3	5	4	5	1	20	12.66%
Suicide gesture/threat	5	5	5	2	0	2	19	12.03%
Self mutilation	0	1	0	0	1	0	2	1.27%

* *METO tracks up to five major reasons for admission, so totals can exceed 100%.*

How Long Do They Stay?

There were a total of 181 discharges from the METO program during the 6-year period 7/1/97 to 6/30/03 (see Figure 1). The average length of stay for individuals discharged from the METO program was 501.08 days or 1.37 years. Both the average length of stay and median length of stay at discharge seem to be increasing (see Figure 4.4). The average length of stay for persons residing in the METO program on 9/30/03 was 684 days. As of 9/30/03, there were 6 individuals residing in the METO program with length of stays greater than 1000 days.

Figure 4.4		
FY	Average LOS in Days	Median LOS in Days
1998	445.8	250
1999	390.7	206
2000	481.7	446
2001	439.1	349
2002	546.1	408
2003	744.0	567

Where Do they Go When Discharged?

Only 18.76% of the individuals admitted to the program returned to the same place of residence where they were residing at the point of admission. In terms of the type of placement site, the majority of discharges (65.75%) were to Corporate Waiver Group homes (95% privately operated, 5% state operated). The next most frequent placement was to a community ICF/MR group home (8.84%, all privately operated). The third most frequent placement site was to another a Mental Health Unit of another Regional Treatment Center (7.18%). For a complete listing of placement sites see Figure 4.5.

Figure 4.5. Discharge Residential Site	N	Percentage
Home Immediate Family	16	8.84%
Home Extended Family	1	0.55%
Foster Family	3	1.66%
Foster Corporate		
Private	113	62.43%
State Operated	6	3.31%
Own Home with 24-Hr Supervision	3	1.66%
Own Home with less than 24-hr Supervision	2	1.10%
ICF/MR Community		
Private	16	8.84%
State Operated	0	0.00%
ICF/MR RTC	0	0.00%
Nursing Facility	1	0.55%
Board and Care	0	0.00%
Community Mental Health Facility	0	0.00%
Mental Health - Adolescent	0	0.00%
Other	7	3.87%
RTC Mental Health Unit	13	7.18%
Total	181	

How many are readmitted?
Of the total admissions, 22.08% were readmissions. Of those readmissions 14.29% were the result of revoked provisional discharges. The average length of time between discharge and readmission has been just over 240 days.

How Much Does It Cost?
The cost of services of METO cannot be compared to any other program due to its unique design, purpose and admission criteria. It is the only program that provides these specialized short-term services to a small, yet unique portion of the population with complex needs.