Office of the Ombudsman for Mental Health and Mental Retardation

2000 / 2001 Biennium Report to the Governor on Agency Activities

Ombudsman Overview of Activities

The Office of Ombudsman for Mental Health and Mental Retardation is an agency with 19 staff members. The agency is charged with providing several services to clients. One primary function is the review of circumstances surrounding care and treatment of persons with mental disabilities both individually and systemically, and if necessary, recommend improvements and advocate for change in the care delivery system. The other primary function is to review the circumstances surrounding the death or injury of a client. The serious injuries are assigned to regional ombudsman located throughout Minnesota. The death reports are assigned to the Medical Review Unit for review and presentation to a Medical Review Sub-Committee of the Ombudsman's Advisory Committee. At the time of this report the Medical Review Unit had three staff members who were devoted to receiving, assessing and reviewing the circumstances surrounding a death. The agency receives between 400-500 death reports per year. In addition the agency houses the Civil Commitment Training and Resource Center, which provides updated information and training to clients, families and professionals involved in Minnesota's Civil Commitment proceedings.

The 2000/2001 Biennium brought challenges and opportunities to the Office of Ombudsman for Mental Health and Mental Retardation. Much of the agency's time was spent on an in-depth review of the medical review function of the agency. The agency had accumulated two years of data under the new computerized case management tracking system. The Ombudsman had also engaged in conversations with numerous stakeholders about the appropriate role of the medical review process, what priority it should receive in the agency and what resources are needed. After much discussion, the Ombudsman sought to have a comprehensive review done by an outside third party. The Management Analysis Division (MAD) of the Department of Administration was chosen to conduct a review and develop recommendations for the future of the Medical Review function.

As part of their review, MAD was asked to conduct focus groups with agency staff, providers of service, consumers and families, other stakeholder organizations, other state agencies who conduct maltreatment and licensing investigations, the Governor's Office and state legislators. MAD was asked to report to the Ombudsman if stakeholders know about and understand the role of medical review process, if they view this as an important function to be performed compared to other duties assigned to the agency, and what resources are needed to perform it effectively. In addition they were asked to make recommendations about ways to improve both the process and the effectiveness of the medical review function.

The report was presented to the Ombudsman for Mental Health and Mental Retardation in November of 2000. In general the report concluded that the function was an important function and should be continued and improved. It also found that the resources available for medical review were not sufficient to perform medical reviews in a timely and effective manner leading to a backlog in pending cases. In addition, despite efforts of the staff of the medical review function to educate them, there is confusion among some stakeholders as to the role of medical review and whether or not it duplicates the efforts of investigatory actions done by other agencies. The report acknowledged that some

Mission

. . . Promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

positive changes were made from 1995-2000. Progress had been made in the areas of outreach and communication on broad issues through Medical Updates and the report recommended that these efforts should continue and where possible expanded and improved. The report contained a number of specific recommendations on process, communications and coordination with others and use of technology. A number of the recommendations were already under consideration and development by the staff of the medical review unit, while other recommendations provided the agency and staff with a new way of looking at this function.

The most immediate problem facing the Ombudsman's medical review staff is the issue of the backlog of death reviews. As a result of effective outreach with service providers on their obligation to report death and serious injuries to the Ombudsman, we have seen a steady increase in the number of cases reported. Even with effective triaging of cases, it was clear that it was not possible to handle the sheer volume of cases with the staff available. However, given the overall call volume of the agency, there are insufficient resources to perform each of the agency functions fully and completely as envisioned with the creation of the agency. The challenge faced by the agency is to ensure the best distribution of resources within the agency, look at alternative ways to develop additional resources and at the same time determine what work can no longer be done.

As a result of the assessment of the medical review function of the agency, the Ombudsman and her staff have embarked on a work plan that includes improvements in the following areas:

- Case Backlog
- Streamline Intake
- Case Triage and Assessment
- Communications
- Use of Technology

As we move into the 2002/2003 Biennium, the agency has had to eliminate two positions within the agency due to budget constraints. However, the Ombudsman is committed to looking for every opportunity to continue improvements to the medical review that can be done without additional resources.

Ombudsman Co-location Agreement

Over the past eight years there have been numerous reports and studies that have addressed the issue of Minnesota's various Ombudsman programs. Since there are 10 different state based Ombudsman programs that serve various groups of Minnesota citizens, there was discussion about confusion and efficiency. However, despite various proposals, the variety of stakeholders with interest in the Ombudsman functions could not come together with a unified approach to this issue. It was agreed that if any type of co-location or shared services agreement were to succeed, it would need to happen over time and with the agreement of the various groups.

The Ombudsman for Mental Health and Mental Retardation and the Ombudsman for Older Minnesotans determined that it would be beneficial to co-locate if the details between the agencies could be worked out. There was a unique opportunity to make this happen as a result of additional space becoming available next to the Ombudsman for Mental Health and Mental Retardation. It was felt that each Ombudsman could continue to serve their unique population in an independent manner but provide those services in a supportive and cost effective manner. The Ombudsman for Mental Health and Mental Retardation worked with the Department of Administration's Building Codes Division to split the available space vacated by the Health Department. The Ombudsman for Mental Health and Mental Retardation amended their lease for the additional space with the agreement to sub-lease most of it to the Ombudsman for Older Minnesotans.

An agreement spelled out the relationship and the move was made in the fall of 1999. The co-location has proven far more beneficial than expected. The agencies share common rooms like conference and lunchrooms. There have also been opportunities to share equipment and supplies. But the biggest benefit has been the interaction between staff members of the two organizations. The two Ombudsman programs have done joint training on topics of common interest, they have collaborated on cases where in the past there may have been some duplication, and they have served as peer support for each other when needed. In the end, the co-location of programs while keeping the service missions unique has paid off for both programs.

Ombudsman Advice Not Heeded
Expensive to the State of Minnesota

One of the roles of the Ombudsman for Mental Health and Mental Retardation is to review and evaluate issues that affect clients served by Minnesota's mental health system and make recommendations early in the process and at the lowest possible level in an effort to prevent the need for expensive litigation. The cost to taxpayers for defending the state in litigation is expensive but necessary in some cases. However, whenever possible, the state and its operating agencies should attempt to anticipate and prevent the need to defend the state in expensive court cases.

During the 1990s the state was seeing an explosive growth in the number of persons being committed under Minnesota's Psychopathic Personality (PP) and Sexually Dangerous Persons (SDP) provision of the Civil Commitment Act. Most persons committed as a PP in the early part of the decade were housed at the Minnesota Security Hospital in St. Peter. With the closure of the Moose Lake Regional Treatment Center, plans were made to move clients into community based treatment and housing options and turn the state owned buildings over to the Minnesota Department of Corrections. At the same time, plans were developed by the Department of Human Services (DHS) to build a new state run facility in Moose Lake to house the growing PP and SDP populations. All persons committed under this provision of the statute were to be moved from St. Peter to Moose Lake upon its completion.

The state expenses for defending this law suit all the way to Supreme Court were unnecessary and an expensive price to pay.

With the development of this new facility, all PP and SDP treatment was to be covered by a new licensing rule commonly referred to as Rule 26 that was a unique hybrid of treatment. This would be different than program rules for the Minnesota Security Hospital for those committed as Mentally Ill and Dangerous or the other Regional Treatment Centers (RTC) throughout the state. It was DHS's position that since they were not referring to this facility as an RTC, they were not required to have a Hospital Review Board as is required under Minnesota Statute 253B and the Reome court decision.

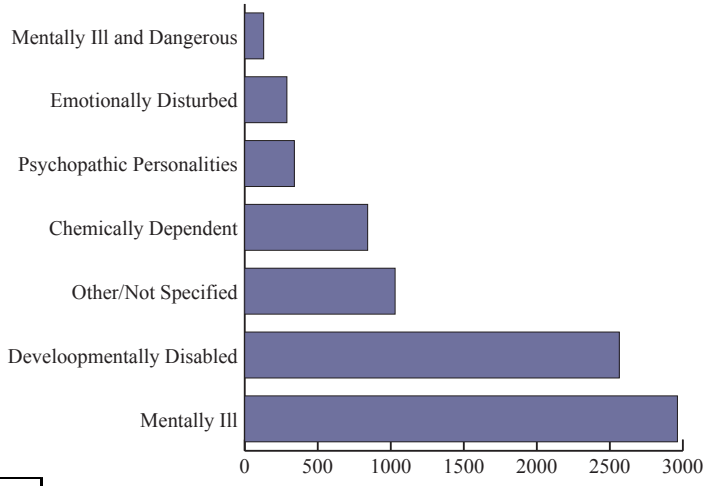
During the development of Rule 26 and after the opening of the Moose Lake PP SDP Treatment Center commonly referred to as the Minnesota Sex Offender Program (MSOP), it was the position of the Ombudsman that this facility was required to have a Hospital Review Board. Clients who had been used to the Hospital Review Board at St. Peter contacted the Ombudsman to complain. The Ombudsman and her staff had numerous conversations with DHS including the facility director, medical director and assistant commissioner encouraging DHS to establish such a board whether or not they believed it was required by statute. The Ombudsman also sent written correspondence to that effect. The Ombudsman felt that DHS's interpretation of the requirement under MN Stat. § 253B was open for interpretation and might not be upheld in court. In addition, a hospital review board provides a low cost constructive process that can advise the facility and the DHS commissioner about problems within their facilities along with potential solutions, serve as a "relief / pressure valve" for potential unrest in the facility and reveal problems of rights violations that could lead to expensive litigation.

In the end, DHS chose not to follow the recommendation of the Ombudsman. Subsequent to that decision, 16 attorneys on behalf of 28 clients of the MSOP program filed a law suit against DHS and the State of Minnesota for their failure to provide a Hospital Review Board. The case was filed in Hennepin County Court then moved to Ramsey County Court. The Court of Appeals and ultimately to the Minnesota Supreme Court ruled against the DHS interpretation, concluding that the Moose Lake MSOP program met the definition of a regional treatment center and remanded the matter back to Ramsey County Court.

Client Services Overview

During the biennium Minnesota has continued to deinstitutionalize and downsize state operated services. Treatment priorities have shifted, available funding has eroded, and the safety net for persons with mental disabilities has become even more faint. At the same time the need for high quality community treatment beds was increasing but beds were largely unavailable. This biennium has brought significant change for this agency. Staff turnovers and loss of positions during a time of greater visibility and requests for service has negatively impacted staff.

Contacts by Disability Groups for Biennium *



Types of Issues Raised *

Type of Issue	FY 00	FY 01	Biennium Total	Percentage
Abuse/Neglect	201	273	474	7%
Child Custody/Protection/Visitation	9	78	87	1%
Civil Commitment	133	229	362	5%
Client Rights	84	648	732	10%
County Social Services	15	198	213	3%
Criminal	106	84	190	3%
Data Privacy/Client Records	59	139	198	3%
Death	433	477	910	12%
Dignity & Respect	272	299	571	8%
ECT	3	4	7	0%
Education System	56	59	115	2%
Employment	14	51	65	1%
Financial	107	141	248	3%
Guardianship/Conservatorship/Rep Payee	13	92	105	1%
Housing	110	121	231	3%
Information	376	254	630	9%
Insurance	34	38	72	1%
Legal	131	290	421	6%
Managed Care	46	28	74	1%
Medical Issues	157	232	389	5%
Placement	312	337	649	9%
Psychotropic Meds	143	293	436	6%
Public Benefits	66	57	123	2%
Public Policy	42	31	73	1%
Referral	1	4	5	0%
Restraint/Seclusion/Rule 40	53	40	93	1%
Restrictions	154	229	383	5%
Serious Injury	900	1,037	1937	27%
Special Review Board	11	1	12	0%
Staff/Professional	211	342	553	8%
Training	4	47	51	1%
Transportation	8	21	29	0%
Treatment Issues	480	473	953	13%
Violations of Rule or Law	30	94	124	2%
Waivered Services	3	19	22	0%
Other	19	185	204	3%

* ***Percentage exceeds 100% because some clients have more than one disability or more than one issue. Percentage is based on 7,291 Contacts during the Biennium.***

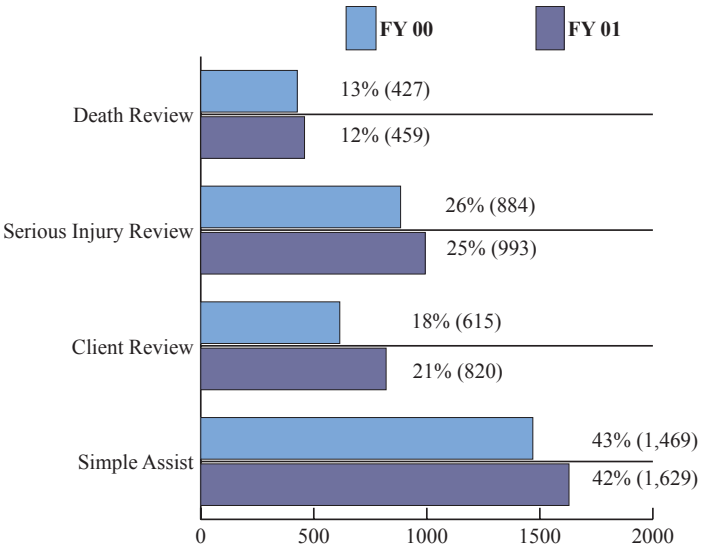
During the biennium 42% of the services that our regional ombudsman provide was direct assistance to consumers and their families. An additional 20% of the requests for service required extensive time and effort to resolve issues. Thirty eight percent of the issues involved treatment, including general medical issues, placement, psychotropic medications, restrictions, and treatment issues. Twenty five percent of our cases involve abuse/neglect, dignity/respect and client rights. Issues that appeared to have increased significantly during the biennium are: placement, legal issues, guardian/conservatorship, data privacy, child custody/protection/visitation, civil commitment, medical issues, psychotropic medications, restrictions, and staff/professional issues. County social service contacts also took a jump from FY00 to 01, from 15 to 198. That does not represent that we are necessarily investigating more counties. This represents more county agencies seeking collaborative assistance.

As in the past, during this biennium two populations received significant services. Persons with mental illness made 2,963 contacts or 41% of our work, persons with developmental disabilities accounted for 2,565 contacts or 35% of our total services. Together these populations account for 76% of our work.

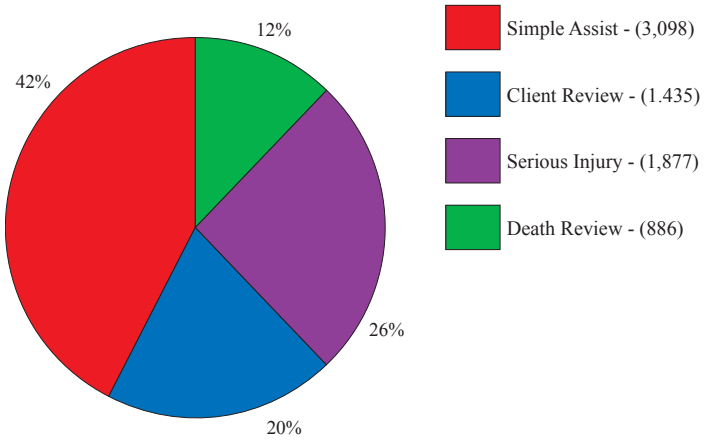
Cooperative Advocacy Pays Off for Child with Developmental Disabilities

An Association for Retarded Citizens (ARC) advocate asking for assistance with a social service appeal contacted a regional ombudsman. A family wanted to appeal a county's denial of a request for a MR/RC waiver. The county had denied the waiver stating that based on the school district's psychologists assessment, their daughter was too high functioning and therefore not at risk of an ICF/MR placement. The regional staff reviewed the information, including the school assessment and believed that the assessment was based on the girls IQ. He recommended having another assessment done by a psychologist who is experienced with mental retardation. The family and ARC advocate were able to find an experienced psychologist who could do a behavioral assessment on short notice. The new assessment showed that the girl indeed was functioning at a much lower level than the school had assessed. The psychologist also stated in the evaluation that the school assessment focused more on how the girl performed in a special education program than how she functioned at home or in the community. After reviewing the new assessment and having the family give a copy to the county social service agency, the regional ombudsman contacted the county case manager. He discussed the fact that the new assessment supported that the girl did indeed meet the guidelines for a MR/RC waiver and that they would be introducing the assessment at the appeal hearing in three days. Later that afternoon, the regional staff received a call that the appeal hearing was canceled due to the fact that the county had reconsidered the request and had approved the MR/RC waiver for the girl.

Contact by Type by Fiscal Year



Contacts by Type Total for Biennium



Working Outside of the "Box" We Can Get Wonderful Results

While on vacation, a regional staff ombudsman received an e-mail from a sister who lost contact with her brother when he was four years old, because the parents put him in Rochester State Hospital. The parents won't talk with their daughter about what happened to her brother (now 41 years old). She requested help from a regional ombudsman in locating her brother. These siblings are twins so there's probably a bond stronger than normal siblings. This request was typically outside what our agency would do. Normally locating lost family is not something we do. However, this sister said that her brother was a Ward of the State and after consultation with peers, a call was made to the Public Guardian office at the Minnesota Department of Human Services. The regional ombudsman was told that the brother had died in 2001. The regional ombudsman decided to check our Ombudsman Data System to see if the death was reported before calling the sister. No death was listed in our data system. Several other phone calls were made and no report of death could be found. We called the facility that had been reported as the place this client lived. They

(Continued on Page Eight - **Results**)

Civil Commitment Training and Resource Center:
An Overview of Past and Future

As first reported in our 1998-99 Biennium Report the Advisory Task Force on Civil Commitment recommended in the task force report that a statewide civil commitment training and resource center be created to provide interdisciplinary training and information regarding the civil commitment process and related topics. The Office of Ombudsman for Mental Health and Mental Retardation received funding in the 1997 budget to develop and implement the training and resource center. The Office of Ombudsman contracted with the Hamline University School of Law and the Minnesota Attorney General's Office to provide the training component for the Center starting in March 1998 through June of 1999. Hamline University and the Attorney General's Office provided a comprehensive training for judges, attorneys, case managers and families. Over 800 professionals, family members and consumers were trained on changes in the Civil Commitment Act. These seminars provided detailed, specialized training on topics in civil commitment, pre-petition issues, post-petition issues, neuroleptic medications and more effective advocacy. The training locations included Mankato, Bemidji, St. Cloud, St. Peter and Minneapolis. A Civil Commitment Manual was developed to enhance the training experience.

In September 1999 the Office of Ombudsman created a Handbook for Substitute Decision-Makers. A training kit was developed that included the manual and videotape. These materials were to assist persons making decisions concerning administration of neuroleptic medications. This office also developed a number of fact sheets, which included topics such as: cost of treatment, civil commitment process, early intervention, effective representation and commitment act hold orders. All the materials developed by the Civil Commitment Training and Resource Center have been made available on our website at:

http://www.ombudmhmr.state.mn.us

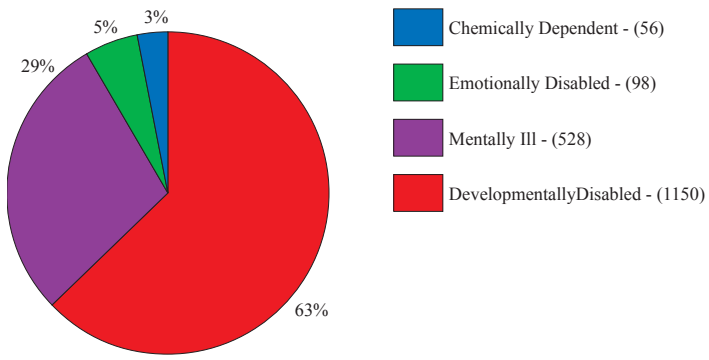
In March of 2001 the staff person primarily responsible for upkeep and maintenance of the civil commitment training and research center resigned and due to budgetary issues this position has not been replaced. However, the Office of Ombudsman is committed to this activity and recognizes the need consumers and their families have for accurate, up-to-date information about civil commitment. Although our focus is on consumers and their families, we also provide training and information to county case managers, mental health professionals, law enforcement and court personnel.

During the 2001 legislative session a number of changes were made to Minnesota's Civil Commitment Act. One of our regional staff in cooperation with the Department of Human Services have developed plans to provide training in FY 02. These legislative changes instructed the Ombudsman to create informational notices for distribution to proposed patients during the early stage of a commitment process. In consultation with the Department of Human Services and the Hennepin County Attorney's Office we drafted notices to be given to proposed patients of civil commitment for mental illness, chemical dependency, and developmental disability; or as a mentally ill and dangerous person and a third notice for persons involved in early intervention. These notices would be given to a proposed patient during the pre-petition screening process by the screening team. During FY 2002 the Office of Ombudsman will conduct training on the commitment act changes, in partnership with the Department of Human Services. We will ensure that all counties and pre-petition screening teams are provided the "new" civil commitment notices and we will update our website to provide the public with the most current information available.

Medical Review Subcommittee

The Medical Review Subcommittee (MRS) is empowered under MN Stat. 245.97, Subd. 5, and meets on a regular basis throughout the year to review deaths and serious injuries of clients that meet established guidelines.

Serious Injuries by Disability for Biennium



The Medical Review Subcommittee does not do an in-depth review of all cases that have been reported. As mentioned above, there are established guidelines used to determine when a reported death needs to be prepared for review by the MRS. The purpose of the MRS reviews is to seek opportunities to improve the care delivery system for the living. The MRS does not have a punitive focus and avoids duplication of the work of agencies such as Office of Health Facility Complaints and DHS Licensing that do detailed investigations and have sanction authority. If the MRS finds a situation that needs that kind of investigation a referral is made to the appropriate agency or agencies or licensing board(s). The MRS works collaboratively with the referral agency or board but avoids duplication of effort.

The purpose of the MRS reviews is to seek opportunities to improve the care delivery system for the living.

In looking for opportunities to improve the care delivery system the MRS looks not only at the individual cases but also for patterns and trends. If patterns or trends appear the MRS uses that opportunity to make recommendations to the delivery system. These recommendations may come in the form of a Medical Update.

These are available on our website at: **http:www.ombudmhmr.state.mn.us**

Type of Serious Injury	FY 00	FY 01	Total	Percentage
Burns	42	75	117	6.06%
Complication of Medical Treatment	11	16	27	1.40%
Complication of Previous Treatment	5	8	13	0.67%
Dental Injury	31	17	48	2.49%
Dislocation	20	32	52	2.69%
Eye Injury	13	11	24	1.24%
Frostbite	0	5	5	0.26%
Head Injury	48	40	88	4.56%
Ingestion of Harmful Substance	27	36	63	3.26%
Internal Injury	7	12	19	0.98%
Laceration	52	40	92	4.76%
Major Fractures	288	240	528	27.34%
Minor Fractures	270	347	617	31.95%
Multiple Fractures	15	39	54	2.80%
Near Drowning	1	3	4	0.21%
Other	75	105	180	9.32%
Total	**905**	**1026**	**1931**	**100.00%**

Over 6,000 Seasonal Alerts are mailed at least twice each year. The Summer Alert covers such topics as Heat Stroke, Insect Sting, Water Safety and Burn Injury. The Winter Alert includes information on Hypothermia and Frostbite along with the latest wind chill chart. While some topics may seem obvious, persons with disabilities have unique needs that caregivers need to be made aware of. The MRS shares what it has learned in an attempt to assist providers so that they can avoid the same or similar problems.

(Continued on Page Eight - **MRS**)

(**MRS** - Continued from Page Seven)

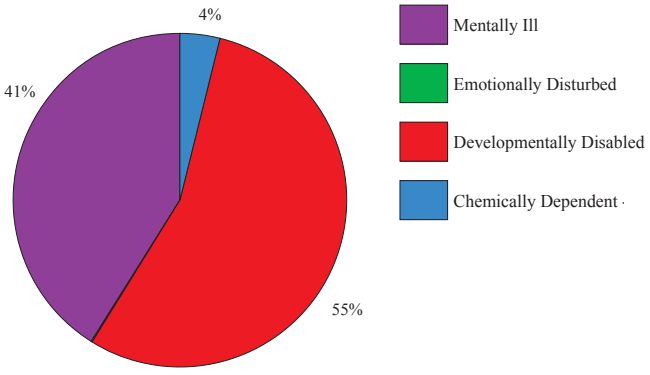
The following new Medical Alerts have been distributed:

- Delay of Treatment Alert, December 2000
- Burn Injury Alert, May 2001

Type of Death	FY 00	FY 01	Biennum Total	Percentage
Accident	12	25	37	4.18%
Homicide	3	3	6	0.68%
Natural	356	366	722	81.58%
Suicide	31	21	52	5.88%
Undetermined	22	46	68	7.68%
TOTAL	**424**	**461**	**885**	**100.00%**

There were 424 deaths reported to the Medical Review Coordinator in FY 00 and 461 deaths reported in FY 01. This total of 885 deaths compares with 587 deaths reported in the previous biennium. There were 1,931 serious injuries reported in the 2000/2001 biennium. This compares with 1,759 serious injury reports from the previous biennium. The increase in reported death and serious injury reports is in part due to increasied outreach by the Office and improved compliance with reporting requirements by the providers.

Death by Disability for Biennium



Future Challenges

In the next biennium the Office of the Ombudsman will embark on a broader implememtation of the recommendations in the Management Analysis Report related to the Medical Review Subcommittee Fuctions.

In addition, due to budget concerns, all services need to be evaluated using lessons learned during the Medical Review Implemtation.

(**Results** - Continued from Page Five)

didn't know who this brother was. We inquired about who the case manager for the brother was. We followed up with the county case manager to discover that the brother was alive and well living in Rochester. The case manager was delighted to hear from us because they have been trying to locate family for two years without any luck. The case manager and our regional staff person exchanged information. A roller coaster ride of emotion ensued for all parties. When our regional ombudsman called with this great news they experienced a very thankful sister, so thankful it was almost embarrassing! The sister stated that she had been checking her e-mail everyday since sending the note to our regional ombudsman.

These are the times that help our staff soar like eagles with a natural "high." At times we step out of our box and put time and effort into cases that could very easily be put aside as something that we are not required to do or do not have the time to do. However, when work is frustrating and stressful, it is case stories like this that help staff to continue the work they do. Rewards are not always based on money. Staff do affect people's lives in positive ways. In this case staff achieved a happy ending, but even more importantly a happy beginning for a brother and sister lost for 37 years.

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