2010/2011 Biennium Report to the Governor

Mission Statement

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.

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State of Minnesota

The Office of Ombudsman for Mental Health and Developmental Disabilities

Ombudsman's Overview

What exactly is an Ombudsman? There are many legal, technical and operational definitions but the easiest concept to understand is that an Ombudsman is a 'watch-dog' or 'citizen protector' within the government. The Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) deals in thousands of situations where individuals have problems with the systems from which they need services. Based on what the OMHDD learns during its reviews of these cases and situations, it is able to monitor how well these systems and services deliver services consistent with what the individual needs. By reviewing what does not work in the current systems, the OMHDD is in a position to make recommendations for changes and improvements to the various systems.

The OMHDD continued to follow up on the METO Report, "Just Plain Wrong", issued in 2009. After the report was issued, a group of clients and their families filed a Federal Class Action Lawsuit against the Department of Human Services (DHS) for violation of their Civil and Human Rights. During the 2010/2011 biennium the Ombudsman continued to monitor the work of improving treatment at the Minnesota Extended Treatment Options (METO) program in Cambridge, Minnesota. The result of the law suit was a Settlement Agreement often referred to as the Jensen Settlement Agreement. This agreement provided monetary compensation for certain class members along with agreement that the state will develop an Olmstead Plan under the American's with Disabilities Act. The Olmstead Plan requires individuals with disabilities to receive services in the most integrated setting possible. In addition the state agreed to make changes with the METO program and to have a workgroup propose changes to the current allowed uses of programmatic or therapeutic use of restraints referred to as Rule 40. The agreement specified that services should be delivered in a manner that is consistent with Person Centered Thinking and Planning as well as Best Practice Standards. That agreement was developed and submitted to the court in June of 2011.

The Ombudsman's focus was to ensure that METO or subsequent facility continued to use positive behavioral programming and decrease the use of restraints at the facility. The two OMHDD staff involved with the original year-long investigation are continuing the follow up work. The Ombudsman has committed to participating in and monitoring these changes.

The OMHDD houses the Civil Commitment Training and Resource Center. During this biennium the OMHDD also focused on issues involving the civil commitment process. These issues included individuals being placed on hold orders without statutory requirements being followed. The OMHDD was involved in meetings regarding a lack of bed space to treat people on holds or those who have been committed and awaiting a state operated bed to become available. The OMHDD was also involved in reviewing and consulting on language for amendments to the Civil Commitment and Treatment Act and the related Interstate Contract statute.

During this biennium the Death and Serious Injury reviews continued to be a high priority for the OMHDD. The Medical Review Unit consisted of one full-time RN, one part-time RN, and a part-time serious injury reviewer, and support staff who entered reports received from programs and facilities. There were 1,259 Death Reports and 2,829 Serious Injury

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Client Services Overview

The issues with the greatest number of contacts that staff worked on were abuse/neglect, civil commitment, and client rights.

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Regional staff continued to keep pace with requests for services despite staffing challenges in the current biennium. During the extended leave of a staff member who covered a busy region in the state, other regional staff worked to ensure no Ombudsman service interruption for clients in those counties.

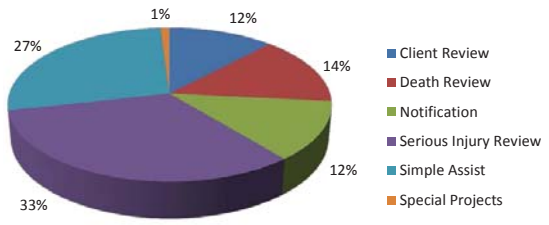
The issues with the greatest number of contacts that staff worked on were abuse/neglect, civil commitment, and client rights. Abuse and neglect issues come to the agency by calls from staff at facilities, family members and clients as well as reports from licensing agencies. The focus of the OMHDD is to ensure that the reports are investigated by the appropriate licensing agency. The staff will also follow-up to see if there are services needed that are not offered.

Civil commitment contacts may be from someone seeking information or technical advice on the commitment process or a client asking for the regional staff to assist in avoiding a commitment altogether. With the OMHDD housing the Civil Commitment Training and Resource Center, its staff is trained on the civil commitment law and how to work with clients on this issue. Some examples of these issues would be to work with the treatment team on less restrictive options the client may be willing to participate in but were overlooked; trying to clarify comments the client made but were misinterpreted, or looking into whether or not the laws were followed.

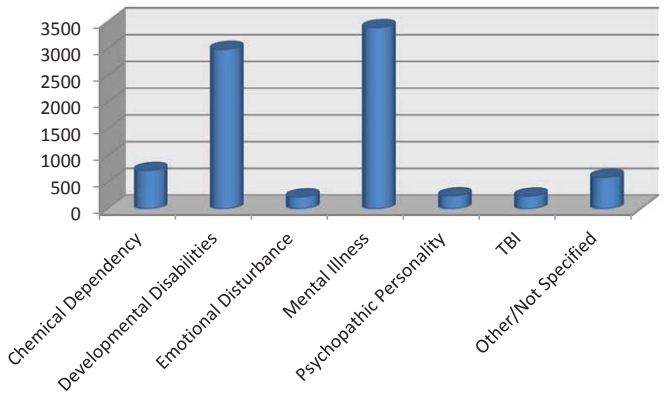
Client rights issues continue to be one of the main issues the agency deals with. Many times clients are powerless to advocate with the provider to not restrict or limit their rights. Many times restrictions are done in an effort to protect the individual but the restrictions are not always necessary as there may be other options that would work. The agency considers rights issues a high priority.

The OMHDD has also seen an increase in contacts regarding guardianship. These calls may be questions on how to pursue guardianship, how to dismiss or change a guardian, and others have to do with disagreements with decisions a guardian has made. Regional staff will work with the client to advocate for the guardian to change his/her mind on certain restrictions that may be made but are not necessary to ensure the client's health and safety.

Contacts by Type for Biennium



Contacts by Disability for Biennium



Placement is also another issue in which the OMHDD receives frequent contacts. Contacts are often regarding the client needing a placement and nobody is willing or able to find one, or a client needing/wanting to move to a different placement because he/she is having difficulty with their current placement. Contacts can also be related to finding a hospital bed because of availability or appropriateness challenges.

The disabilities the OMHDD receives the most calls on the most continue to be persons with a developmental disability or with a mental illness. Persons with chemical dependency are the group with the next highest number of calls, followed by children with emotional disturbance.

The majority of the cases the regional staff members receive are of two types. One is a simple assist and the second is a client review. A simple assist is a case where the issue can be handled fairly quickly by giving the person requested information or advising on how they can proceed. It can also include a case where the agency has no authority to act so the regional staff refers to an agency or group that can assist. A client review is a case in which the staff is much more involved. The majority of cases handled by OMHDD regional staff are client reviews, which can be very time consuming. The staff for example, are reviewing information, contacting providers or agencies on the client's behalf, and attending meetings with or to advocate on behalf of clients.

Placement is also another issue in which the OMHDD receives frequent contacts.

Type of Issue	FY 2010	FY 2011	Biennium Total	Percentage
Abuse/Neglect/Exploitation	681	684	1,365	10.24%
Advance Directive	3	3	6	0.05%
Chemical Dependency	35	50	85	0.64%
Child Custody/Protection/Visitation	33	34	67	0.50%
Civil Commitment	528	573	1,101	8.26%
Client Rights	381	438	819	6.15%
Criminal	52	52	104	0.78%
Data Privacy/Client Records	26	40	66	0.50%
Death	620	642	1,262	9.47%
Dignity and Respect	146	212	358	2.69%
ECT	2	2	4	0.03%
Education System	25	32	57	0.43%
Employment	27	22	49	0.37%
Financial	85	88	173	1.30%
Guardianship/Conservatorship/Rep Payee	151	121	272	2.04%
Housing	69	66	135	1.01%
Information	78	118	196	1.47%
Insurance	43	62	105	0.79%
Legal	111	87	198	1.49%
Legal Representative	16	10	26	0.20%
Managed Care	15	19	34	0.26%
Medical Issues	151	199	350	2.63%
Other Contacts	576	545	1,121	8.41%
Personal Care Attendant	28	18	46	0.35%
Placement	263	280	543	4.08%
Psychotropic Meds	67	87	154	1.16%
Public Benefits	91	75	166	1.25%
Public Policy	20	17	37	0.28%
Referral	26	18	44	0.33%
Restraint/Seclusion/Rule 40	20	23	43	0.32%
Restrictions	86	90	176	1.32%
Serious Injury	1,379	1,422	2,801	21.02%
Social Services	170	176	346	2.60%
Special Review Board	21	3	24	0.18%
Staff/Professional	190	167	357	2.68%
Training	7	13	20	0.15%
Transportation	12	10	22	0.17%
Treatment Issues	260	221	481	3.61%
Violations of Rule or Law	48	32	80	0.60%
Waivered Services	21	10	31	0.23%
Total	**6,563**	**6,761**	**13,324**	**100.00%**

Medical Review Unit

The Medical Review Unit is composed of three staff people: the Medical Review Coordinator, a part-time nursing evaluator, and a part-time reviewer for serious injuries. The Medical Review Unit teams with the Medical Review Subcommittee, which includes volunteer members of the Ombudsman's Advisory Committee and is empowered under Minn. Stat. 245.97, Sub. 5.

Type of Death	FY 2010	FY 2011	Biennium Total	Percentage
Accident	62	67	129	10%
Homicide	1	4	5	0%
Natural	505	515	1,020	81%
Suicide	40	41	81	6%
Undetermined	12	12	24	2%
Total	**620**	**639**	**1,259**	**100%**

The purpose of the Ombudsman's death review and serious injury review process is to seek opportunities to improve the care delivery system for clients receiving services for mental illness, developmental disabilities, chemical dependency, and emotional disturbance.

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The Ombudsman is notified of all death reports received by the Office both when a report is received and again upon its closure. In addition, the Regional Ombudsman is notified of death reports from his or her region both when the report is received and again upon its closure.

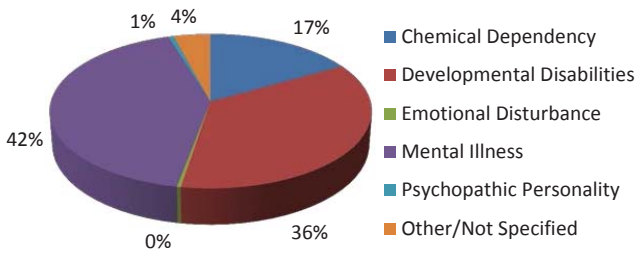
There were 620 deaths reported to the Medical Review Coordinator in FY 2010 and 639 deaths reported in FY 2011. This total of 1259 deaths is lower than the total of 1456 deaths reported during the 2008/2009 biennium but higher than the total of 1069 deaths reported during the 2006/2007 biennium.

Most death reports are closed by the Medical Review Coordinator upon receipt when the information provided is complete or after the collection and review of additional records. Other cases are reassigned for further review by the part-time nursing evaluator. Cases receiving further review are either closed after additional review by the Medical Review Unit or are brought before the Medical Review Subcommittee for its review and for the formulation of recommendations to prevent the recurrence of similar deaths.

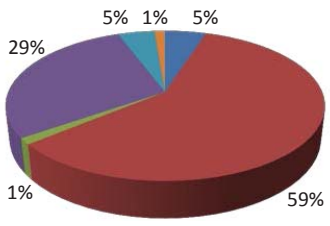
The Medical Review Subcommittee met four times during FY 2010 and five times during FY 2011 to review the deaths and serious injuries of clients that met its established guidelines. During FY 2010, the Medical Review Subcommittee reviewed and closed 19 death reviews. During FY 2011, the Medical Review Subcommittee reviewed and closed 41 death reviews.

While seeking opportunities to improve the care delivery system, the Medical Review Subcommittee looks at not only individual cases but also for patterns and trends. When it identifies patterns or trends, the Medical Review Subcommittee uses that opportunity to make recommendations focused on the care delivery system. These recommendations may come in the form of a letter to a provider or agency, a Medical Update, an Alert, a recommendation for a systemic review by the Ombudsman, or the development of educational tools such as our brochure entitled *Information for Individuals and Families about Suicide Prevention*.

Deaths by Disability for Biennium



Serious Injuries by Disability for Biennium



The following Alerts were created during the 2010/2011 biennium and remain available on the Ombudsman's website:

- Injectable Medication Alert – RISPERDAL® CONSTA® – November 2010
- Provisional Discharge Revocation – May 2010
- Spinal Cord Injury Alert – November 2009

http://www.ombudmhdd.state.mn.us/alerts/default.htm

There were 2829 serious injuries reported during the 2010/2011 biennium. This compares with 3251 serious injuries reported during the 2008/2009 biennium and 2498 serious injuries reported during the 2006/2007 biennium. During the 2010/2011 biennium, 641 serious injury reports were received that were classified as "Other." Most of those reports were instances of clients who either required medical evaluations for medical illnesses or conditions or for incidents of choking. Most serious injury reports are closed upon initial review by the Medical Review Coordinator. The remaining serious injury reports are assigned for further review to the part-time serious injury reviewer or to the Regional Ombudsman.

The Regional Ombudsman is notified of serious injury reports in his or her region both when a report is received and again upon its closure. In addition, the Ombudsman is notified of all serious injury reports received by the Office both when the report is received and again upon its closure.

The Medical Review Coordinator has used the Ombudsman's website to improve communication with providers and clients and to make more efficient use of technology. Editable Death Report and Serious Injury Report forms are available on the Ombudsman's website. Providers, clients, families, and other interested people are encouraged to sign up for the Ombudsman's Medical Alerts E-Mail List Service, which sends an e-mail notification to subscribers when new information is available on the website.

The Medical Review Coordinator produces a series of Summer and Winter Alerts, which are updated and released each year. These are available on the Ombudsman's website. The Summer Alerts – *Summer Alert, Heat Stroke, Water Safety,* and *Insect Sting Alerts* – typically are released in May of each year, while the Winter Alerts – *Winter Alert, Frostbite, Hypothermia,* and the *NWS Wind Chill Chart* – typically are released annually in November. In addition with both the Summer and Winter Alerts, the Medical Review Coordinator provides a cover letter that highlights recent FDA MedWatch warnings and that encourages providers to routinely visit the FDA's MedWatch website at http://www.fda.gov/medwatch/.

In April 2010 at the request of community providers, the Medial Review Coordinator created a training document entitled *Advocating for your client with health care providers*. The PowerPoint document was designed to be used to train residential staff and can be found and freely copied on the Ombudsman's website:

http://www.ombudmhdd.state.mn.us/mrs/Advocating_for_your_clients.pdf

The Medical Review Coordinator and the nurse evaluator are available upon request for tailored presentations at conferences and meetings throughout the state.

The Medical Review Unit thanks you for your interest in and cooperation with the agency's death and serious injury reporting process.

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Type of Injury	FY 2010	FY 2011	Biennium Total	Percentage
Burns (second or third degree)	70	78	148	5%
Complication of medical treatment	16	28	44	2%
Complication of previous injury	16	9	25	1%
Dental Injuries (avulsion of teeth)	20	30	50	2%
Dislocation	17	9	26	1%
Eye Injuries	14	14	28	1%
Fracture	688	706	1,394	49%
Frostbite (second or third degree)	0	2	2	0%
Head Injury (with loss of consciousness)	38	31	69	2%
Heat Exhaustion/Sun Stroke	2	2	4	0%
Ingestion of poison or harmful substances	38	60	98	3%
Internal Injuries	14	9	23	1%
Laceration (muscle/tendon/nerve damage)	39	29	68	2%
Multiple Fractures	62	79	141	5%
Near Drowning	3	1	4	0%
Other	324	317	641	23%
Suicide Attempt	37	27	64	2%
Total	**1,398**	**1,431**	**2,829**	**100%**

Civil Commitment Training and Resource Center

In fiscal year 2010 the Civil Commitment Training and Resource Center (CCTRC) provided nine (9) full training sessions. There were approximately 880 attendees at these trainings. The participants were county social workers, county attorneys, defense attorneys, nurses, psychiatrists, psychologists, hospital social workers, nursing home social workers, and other mental health providers.

The CCTRC also presented at two (2) Crisis Intervention Team (CIT) training sessions for law enforcement and emergency personnel. There were approximately 50 participants at these training sessions.

The CCTRC is involved in a workgroup set up by DHS to look at the transportation problem associated with the use of emergency hold orders and the peace and heath officer authority. This is a workgroup at looking at the best process for transporting individuals to hospitals and from hospital emergency departments to treatment facilities.

In addition to these activities, the CCTRC also responds to questions on the commitment process. These questions come from consumers, county social services, county attorneys, defense attorneys, examiners, court personnel, treatment facility staff, and families. The CCTRC also prepares an annual summary of the legislative changes to the commitment act to send out to professionals dealing with the act and to post on the Ombudsman for MH/DD website. The CCTRC also updates the notices and fact sheets for people to use that are also posted on the website.

The CCTRC is continuing to get requests for training on the commitment and treatment act.

In fiscal year 2011 the CCTRC had an increase in training requests. There were 16 training sessions provided statewide. There were approximately 1,185 attendees for the training sessions. As in FY 2010, many of these were for an individual county or groups of counties. There were a couple trainings that were presented as part of a larger conference and a large session for Department of Human Services CORE training. In the large session, approximately 600 people attended one of two trainings presented via ITV in one day. There were also a few presentations for specific providers who were new at working with the MN Civil Commitment and Treatment Act. There were more requests this year for training that included the process for commitment of individuals as mentally ill and dangerous, sexual psychopathic personalities, and sexually dangerous individuals.

Presentations were attended by county and contracted case managers, nurses, psychologists, chemical dependency counselors, and other service providers. In some areas, law enforcement would attend and the CCRTC was involved in the CIT trainings for law enforcement, although, due to the state ending funding in the previous biennium there were only a few of these. Presentations were also attended by some doctors, both emergency room physicians and physicians who treat people who have been committed. The trainings also included attorneys involved with the commitment process and some judges.

The CCTRC still receives many individual callers for assistance with technical questions. These are usually specific to individual cases that are unusual for the county or have a difficult situation involved on which the county would like an opinion. The CCTRC also continues to update the CCTRC webpage, part of the OMHDD's website, which contains fact sheets and other information regarding the commitment process.

Ombudsman's Overview

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Reports received during the 2010/2011 biennium. Information gleaned from these reviews results in Medical Updates sent through the OMHDD list service to providers around the state in an attempt to reduce or eliminate same or similar occurrences.

The OMHDD served on the Supreme Court Task Force on Guardianship. The efforts of the task force did not recommend changes but a sub group of advocates and families determined that changes were needed to improve the rights of individuals under guardianship. The OMHDD was actively involved in the passage of the Bill of Rights for Wards and Protected Persons. This language was to address concerns expressed by wards and other interested persons regarding restrictions placed on the wards by the guardians. In addition, the legislation allowed for the OMHDD, the Long Term Care Ombudsman or the Disability Law Center to be an interested party in those cases where each may have a client who is subjected to guardianship.

The OMHDD had a Regional Ombudsman out for an extended leave, resulting in other Regional Ombudsman covering one of the state's busiest regions. Client services were maintained at a high level but documentation numbers were down, as mainly higher priority cases were entered. When the position was able to be permanently filled after the close of FY 2011, the OMHDD assigned a new staff member to cover that region.

Other issues the OMHDD worked with others on include Restraint and Seclusion in schools and the University of St. Thomas's University Forum on Social Justice and Mental Health. The Ombudsman anticipates that many of these issues will require ongoing effort into the next biennium.

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"Giving voice to those seldom heard."

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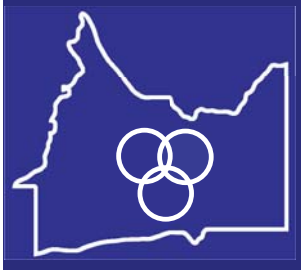

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