MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

"Giving Voice to Those Seldom Heard"

2016/2017 Biennium
Report to the Governor

Ombudsman's Overview

The 2016/2017 biennium brought continuing work to the OMHDD on the Jensen class action lawsuit. This suit was initiated after the OMHDD published a report about the excessive use of restraints in the Minnesota Extended Treatment Options (METO) program, operated by the Department of Human Services (DHS). In 2012 Ombudsman Opheim and Dr. Colleen Wieck were designated by the federal court as advisors to the court and all parties to the lawsuit, and the process to improve the service delivery process continues.
The Federal Court also mandated the development of an Olmstead Plan for Minnesota based on the 1999 United States Supreme Court's decision that ruled people may not be kept in an institution simply because less restrictive alternatives do not exist.

Inside this Report:

Beginning in FY 2016, following a year of transition, the use of punitive practices and procedures, such as seclusion and restraint, were prohibited by providers for persons with developmental disabilities. In their place positive supports were to be used. Providers who used an emergency restraint procedure were required to report that using the Behavioral Intervention Report Form (BIRF). There were fewer BIRFs received in FY16 and FY17 compared to FY14 and FY15. The OMHDD hopes this is a result of positive supports being used more, directly resulting in a decrease in BIRFs.

Contacts and client cases continued to increase in the 16-17 biennium as did the numbers of Serious Injury reports compared to the 14-15 biennium. The OMHDD added a full-time Regional Ombudsman (RO) in an effort to spread out the increasing number of contacts and serious injury reports the ROs are receiving. There is additional information and detail on the Client Review section of this report.

There are two FTEs in the Medical Review Unit (MRU). The MRU received greater than 16% increase in Death Reviews in 16-17 biennium compared to the 14-15 biennium. The OMHDD plans to add a full FTE to the MRU in the 17-18 biennium to alleviate some of the pressure of the increasing number of Death Review cases. There is more information and detail in the Medical Review sections of this report.

In the 2016 legislative session the OMHDD was given the authority to monitor clinical drug trials at the University Of Minnesota to ensure that the trial participants received all the information they needed to make sound decisions and also had OMHDD contact information to get treatment delivery questions answered or to lodge a complaint. This legislative action was the result of a public report by the OMHDD about the death of an individual involved in an earlier U of M drug trial and was suggested by the Office of the Legislative Auditor. There were several statutory changes passed in the 2017 legislative session that will impact the OMHDD in 2018.

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Client Services Overview

The client services section of the OMHDD is made up of nine Regional Ombudsman and one Regional Ombudsman Supervisor. This section handles the calls from clients or interested persons who may have concerns about services for the clients or questions about laws, rules or procedures. The client services section also reviews the serious injuries that are required to be reported to the OMHDD by licensed facilities or programs.

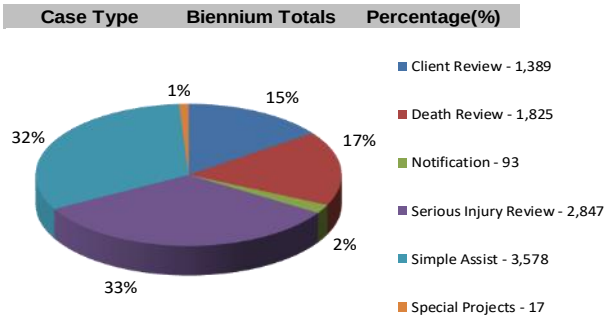
Client services documented a total of 5060 cases. There were 1389 client reviews, 3578 simple assists and 93 notification issues in the 16-17 biennium. Simple assists are cases where the Regional Ombudsman may answer

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

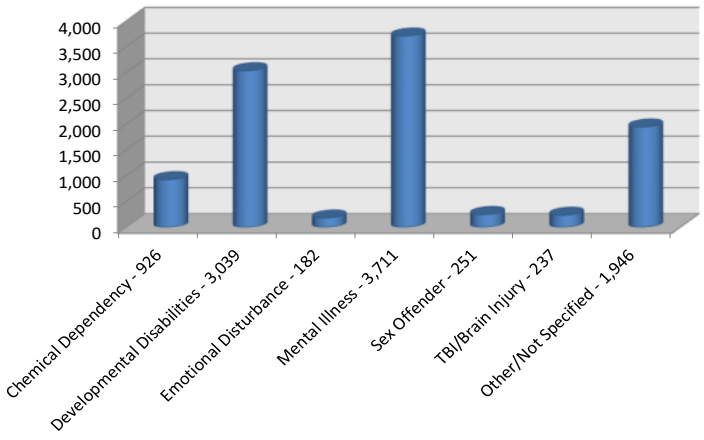
Cases by Type of Issue	FY 2016	FY 2017	Biennium Total	Percentage
Abuse/Neglect/Exploitation	207	258	465	2.48%
Advance Health Care Directive	4	3	7	0.04%
Chemical Dependency	262	270	532	2.84%
Child Custody/Protection/Visitation	48	80	128	0.68%
Civil Commitment	358	378	736	3.93%
Client Rights	1,227	1,515	2,742	14.64%
Criminal	78	78	156	0.83%
Data Privacy/Client Records	62	60	122	0.65%
Death	929	895	1,824	9.74%
Dignity and Respect	552	506	1,058	5.65%
ECT	5	6	11	0.06%
Education System	27	26	53	0.28%
Employment	45	53	98	0.52%
Financial	106	148	254	1.36%
Guardianship/Conservatorship/Rep Payee	437	471	908	4.85%
Housing	146	202	348	1.86%
Information	271	208	479	2.56%
Insurance	82	106	188	1.00%
Legal	88	130	218	1.16%
Legal Representative	6	16	22	0.12%
Managed Care	18	30	48	0.26%
Medical Issues	871	871	1,742	9.30%
Other Contacts	165	97	262	1.40%
Personal Care Attendant	21	18	39	0.21%
Placement	373	404	777	4.15%
Psychotropic Meds	158	245	403	2.15%
Public Benefits	83	73	156	0.83%
Public Policy	9	4	13	0.07%
Referral	46	28	74	0.40%
Restraint/Seclusion/Rule 40	26	19	45	0.24%
Restrictions	44	35	79	0.42%
Serious Injury	1,451	1,396	2,847	15.20%
Social Services	460	572	1,032	5.51%
Special Review Board	24	1	25	0.13%
Staff/Professional	127	121	248	1.32%
Training	6	6	12	0.06%
Transportation	19	19	38	0.20%
Treatment Issues	213	261	474	2.53%
Violations of Rule or Law	32	36	68	0.36%
Total	**9,086**	**9,645**	**18,731**	**100.00%**

questions, make a referral or do research to assist the client. Client reviews require the staff to have more involvement in assisting with the case. Notifications in this section are different than agency notifications and are usually Regional Ombudsman receiving notifications from a client or facility of an action taken. The largest number of cases continue to be from individuals with a developmental disability or a mental illness.

Contacts by Type for Biennium



Contacts by Disability for Biennium



In addition to handling calls from clients the Regional Ombudsman also review serious injury reports licensed facilities or providers are required to report to the OMHDD. The OMHDD received 2847 serious injuries in this biennium. When a serious injury report is received it is assigned to the Regional Ombudsman for that region to review. The Regional Ombudsman will follow up to ensure appropriate medical care was received. In addition, they will look at what caused the injury and see if there were issues of neglect or abuse and if so, ensure those were reported to the appropriate agencies. The Regional Ombudsman may also make suggestions to the facility if there is an issue related to services provided that may not be adequate to meet the client's needs.

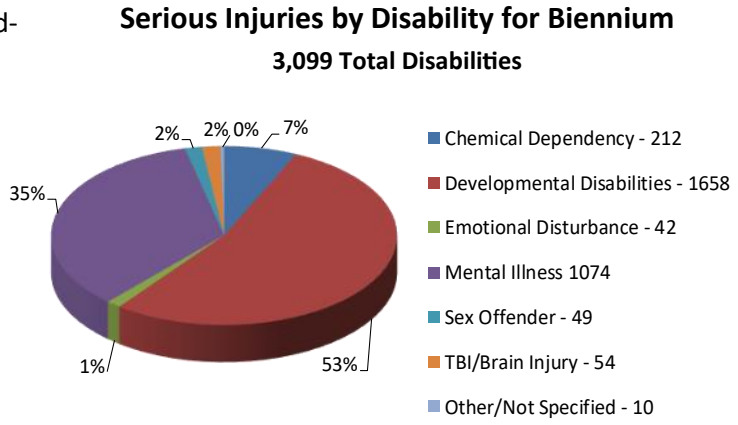
Regional Ombudsman also review notifications from state or county agencies. These include maltreatment investigations, special review board hearings, behavior intervention report forms and nursing home closures. The OMHDD received 9338 notifications this biennium. All maltreatment reports are reviewed by the OMHDD. The OMHDD may take actions based on these notifications. The OMHDD may challenge the findings if it disagrees. The Regional Ombudsman may do their own review of the facility if maltreatment

Notifications	FY 16	FY 17	Total
BIRFS	4008	3583	7591
County Adult/Child Maltreatment Reports	3	1	4
DHS Licensing Reports	651	589	1240
MDE Reports	15	19	34
Nursing Home Closures	14	17	31
OHFC/Licensing No Action Notice	121	69	190
OHFC	21	36	57
PRN/911 - Lift Bridge	42	80	122
Special Review Board Notices/Findings	69	0	69
Totals	**4944**	**4394**	**9338**

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

This pie chart represents the Serious Injuries reported to the OMHDD for this Biennium.

was not found but there were concerns with services provided or not provided to the client. Regional Ombudsman also attend placement meetings for clients being moved due to nursing home closures. Not all BIRFS are reviewed but staff do go in and look at reports, especially if they are working with a client that has had an aversive or restrictive procedure used.



Type of Serious Injury	FY 2016	FY 2017	Biennium Total	Percentage
Burns (second or third degree)	67	66	133	5%
Complication of medical treatment	14	15	29	1%
Complication of previous injury	14	4	18	1%
Dental Injuries (avulsion of teeth)	20	23	43	1%
Dislocation	49	52	101	4%
Eye Injuries	16	13	29	1%
Fracture	787	731	1,518	53%
Frostbite (second or third degree)	1	5	6	0%
Head Injury (with loss of consciousness)	44	38	82	3%
Heat Exhaustion or Sun Stroke	1	8	9	0%
Ingestion of poison or harmful substances	86	68	154	5%
Internal Injuries	17	16	33	1%
Laceration (muscle/tendon/nerve damage)	12	34	46	2%
Multiple Fractures	80	98	178	6%
Near Drowning	2	1	3	0%
Other	253	221	474	16%
Suicide Attempt	11	15	26	1%
Total	**1,474**	**1,408**	**2,882**	**100%**

Equal Opportunity Statement

The Office of Ombudsman does not discriminate on the basis of age, sex, race, color, creed, religion, national origin, marital status, or status with regard to public assistance, sexual orientation, membership in a local human rights commission, or disability in employment or the provision of services.

This material can be given to you in different forms, such as large print, Braille, or on CD-ROM, if you call 1-651-757-1800 Voice or 711 TTY and make a request.

Civil Commitment Training

The OMHDD also houses the Civil Commitment Training and Resource Center (CCTRC). The CCTRC provides training on the commitment process. The CCTRC consists of the Regional Ombudsman Supervisor and one Regional Ombudsman. The CCTRC provided 31 trainings to on the commitment act to counties, treatment providers, attorneys and law enforcement. These trainings involve a presentation on the full commitment process and may include administration of neuroleptic medications. There were 724 attendees at these trainings. In addition to these, the CCTRC also assists with crisis intervention training for law enforcement agencies.

These consist of training on the use of emergency hold orders. The CCTRC also answers technical question related to the commitment process from clients, families, counties and providers.

	FY 16		FY 17	
	Trainings	People Trained	Trainings	People Trained
Commitment Act Training	17	369	14	355
Law Enforcement Crisis Intervention Presentations	7	173	6	143
Total	**24**	**542**	**20**	**498**

The CCTRC provides civil commitment information and referral, consultation and advocacy services.

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Those will be detailed in the 2018-2019 biennial report.

With work increasing staff in all areas of the OMHDD have improved their skills in triage and communication so staff can continue to deliver appropriate and accurate agency assistance to the maximum number possible of Minnesota's vulnerable residents receiving services for mental illness, developmental disabilities, chemical dependency and children with emotional disturbance.

OMHDD 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.

Medical Review Team

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

The Medical Review Team began the biennium on July 1, 2015, with two full-time staff members: the Medical Review Coordinator and a full-time nurse reviewer. Data entry and records management were provided by the Office of Ombudsman's St. Paul office staff.

The Medical Review Team serves as a support to the Medical Review Subcommittee, which includes volunteer members of the Ombudsman's Advisory Committee and is empowered under Minn. Stat. 245.97, Sub. 5.

The purpose of the Ombudsman's death review and serious injury review process is to seek opportunities to improve the care delivery system for our clients receiving services for mental illness, developmental disabilities, chemical dependency, and emotional disturbance. The Medical Review Subcommittee has a quality-improvement focus, and, by statute, avoids duplication of the work of agencies such as the Minnesota Department of Human Services - Office of Inspector General, Licensing Division, and the Minnesota Department of Health - Office of Health Facility Complaints, which perform detailed investigations and have sanction authority. If the Medical Review Team finds a situation that needs that type of investigation, referrals are made to the appropriate agencies or licensing boards. The Medical Review Team works collaboratively with other agencies or boards but avoids duplication of their work.

Death Reports

The Medical Review Coordinator notifies both the Ombudsman and the Regional Ombudsman of every death report both when the report is received and again upon its closure.

There were 930 deaths reported to the Medical Review Coordinator in FY 2016 and 895 deaths reported to the Medical Review Coordinator in FY 2017 for a total of 1,825 death reports during this biennium. During the 2016/2017 biennium, 973 (45%) of the death reports were for clients with mental illness, 660 (30%) of the death reports were for clients with developmental disabilities, and 430 (20%) of the reports were for clients with chemical dependency, as indicated in the accompanying chart.

During the 2016/2017 biennium, 1,410 (77%) of the deaths reported to the Office of Ombudsman were due to natural causes, with 254 (14%) due to accidents, and 93 (5%) due to suicide.

Every death report is reviewed by the Medical Review Coordinator. Every reporter is notified of the receipt of the death report. Additional records may be requested from the reporter at that time, or the reporter may be notified that the death review has been closed with the information provided. Approximately 912 (50%) of the deaths reported to the Medical Review Coordinator are reports of expected deaths, and, if the report is complete, these reviews are closed by the Medical Review Coordinator and a letter of closure is provided to the reporter of the death. The remaining 913 (50%) death

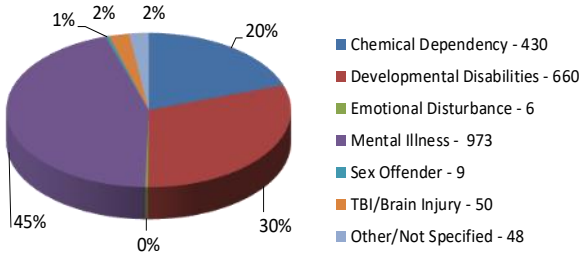
review cases receive further review by the Medical Review Coordinator and the Medical Review Team. These death reports are triaged so that some are closed after further review by the Medical Review Coordinator, or further reviewed by the Nurse Evaluator, with a letter of closure provided to the reporter of the death and to other appropriate agencies or providers. Some death review cases are brought to the Medical Review Subcommittee for its review and the formulation of recommendations to prevent the recurrence of similar deaths.

The Medical Review Subcommittee met five times during FY 2016 (on August 14, 2015; October 9, 2015; February 12, 2016; April 8, 2016; and June 10, 2016), and four times during FY 2017 (on October 14, 2016; December 9, 2016; February 10, 2017; and June 9, 2017) to review the deaths and serious injuries of clients that met its established guidelines. During FY 2016, the Medical Review Subcommittee reviewed and closed 27 death reviews. During FY 2017, the Medical Review Subcommittee reviewed and closed 24 death reviews.

The death review cases brought to the Medical Review Subcommittee met one or more of the following guidelines established by the MRS:

- A death attributed to suicide while a client was residing in a facility or within 30 days of discharge.
- An accidental death of a client under the supervision of paid staff, if lack of supervision is suspected.
- A death of a client in a detoxification unit.
- A death of a client who has been prescribed four or more psychotropic medications, including anticonvulsants.
- A death of a client with a diagnosis or probable diagnosis of Neuroleptic Malignant Syndrome.
- The death of a client taking clozapine.
- A death of a client receiving services that may be related to a delay or failure to diagnose and/or treat in a timely manner.

Deaths by Disability for Biennium



This pie chart represents the Deaths reported to the OMHDD for this Biennium.

Total number of reported deaths for the this Biennium was 1,825.

This total of deaths compares with 1,570 deaths reported in the previous Biennium.

Manner of Death	FY 2016	FY 2017	Biennium Total	Percentage
Accident	127	127	254	14%
Homicide	4	8	12	1%
Natural	730	680	1,410	77%
Suicide	46	47	93	5%
Undetermined	23	33	56	3%
Total	**930**	**895**	**1,825**	**100%**

- A death of a client that may be related to abuse/neglect.
- A sentinel case. A death report that meets none of the guidelines for full review, but full review is appropriate: i.e., review requested by family members or other sources, when a serious injury precedes a death and raises concerns about quality of care, concerns raised by the MRS on previously reviewed cases, Ombudsman staff or others, etc.

While seeking opportunities to improve the care delivery system, the Medical Review Subcommittee looks not only at 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*.

The following Medical Alerts were created or updated during this biennium:

Delay of Treatment, July 2016

Medical Alert - Pulse Oximetry, November 2016

The MRS continues to see death review cases where staff are attentive to clients, but they too often wait until the client becomes unresponsive or stops breathing before calling 911 for medical assistance.

Providers need to ensure that their staff are prepared to recognize an impending emergency and to call 911, based on what they are seeing, without having to wait for a supervisor to tell them to call 911.

The Medical Review Subcommittee recommends that changes in a client's condition be reported to the client's primary health care provider for guidance as to whether the client needs to be seen in the office, seen at Urgent Care, or be transported to the emergency department for assessment.

Ombudsman's Website

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 remain 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 Alert, Water Safety Alert,* and the *Insect Sting Alert* – typically are released in May of each year, while the Winter Alerts – *Winter Alert, Frost-*

bite Alert, Hypothermia Alert, 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 https://www.fda.gov/Safety/MedWatch/SafetyInformation/default.htm

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

The Medical Review Team thanks you for your interest in and cooperation with the Ombudsman's death reporting process.

Medical Alerts are available on the website:
https://mn.gov/omhdd/documents/medical-alerts.jsp

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A report issued under the authority of the Ombudsman, Roberta Opheim

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