2020/2021 Biennium

Report to the Governor

01/17/2023

2020/2021 Biennium Report to the Governor

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Contents

2020/2021 Biennium 1

2020/2021 Biennium Report to the Governor 2

Contents 3

Ombudsman's Overview 4

Client Services Overview 5

Civil Commitment Training and Resource Center 9

Medical Review Team 10

Death Reports 10

Medical Review Subcommittee 12

Ombudsman's Overview

The fiscal year (FY) 2020/2021 biennium saw continued growth in the work of OMHDD despite challenges associated with the global pandemic impacting all agency operations, the effects of which on OMHDD, our staff, and our clients cannot be overstated. OMHDD successfully pivoted all external agency operations to telephone and virtual platforms, while retaining the ability to meet with clients in person if either circumstances warranted or virtual services would be insufficient to meet the need. New processes for administrative and support staff were developed and implemented to ensure seamless continuation of all agency operations and improve efficiencies.

In FY 2020, prior to the inception of the COVID-19 pandemic, OMHDD celebrated the retirement of both the Deputy Ombudsman and the Regional Ombudsman Supervisor. This resulted in some cascading vacancies as existing staff were promoted to fill these agency management positions. The Client Services team did an exceptional job providing backup coverage for nearly ten months until it was back to full capacity in FY 2021. Additionally, after serving as the Ombudsman for Mental Health and Developmental Disabilities for over 28 years, Roberta Opheim retired at the end of FY 2021. Despite this turnover and associated position vacancies, OMHDD served more clients during the FY 20/FY 21 biennium than any previous biennium.

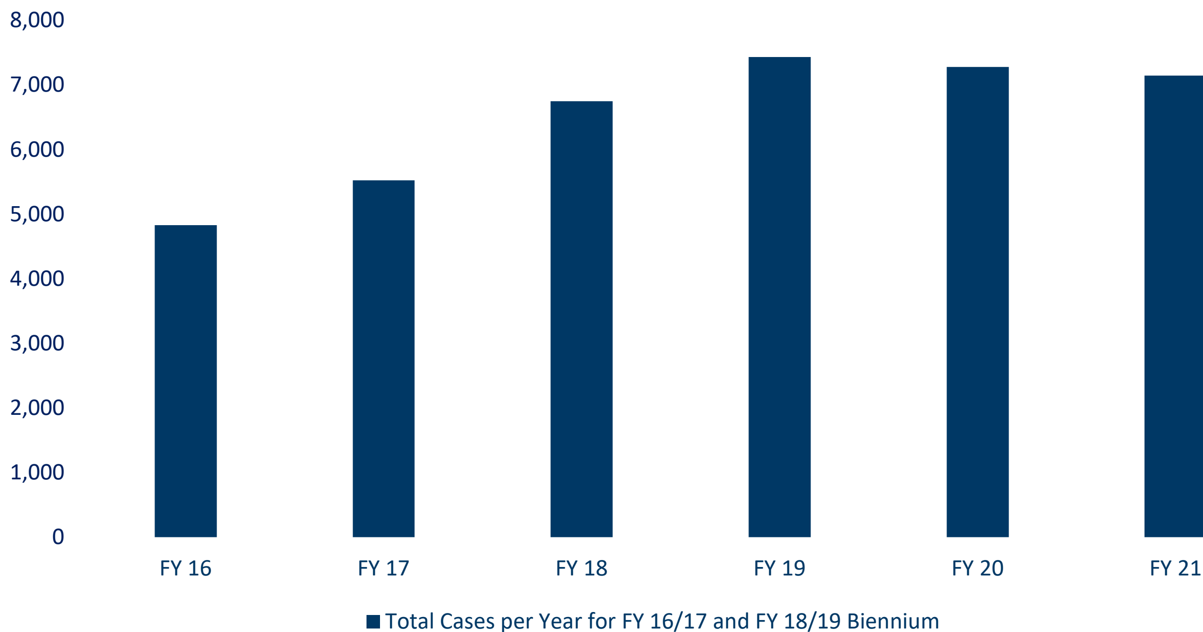
OMHDD staff continued to deliver accurate, effective, and timely agency assistance to as many of Minnesota's residents receiving services for mental illness, developmental disabilities, chemical dependency, and emotional disturbance as possible throughout fiscal years 2020 and 2021. As expected, contacts continued to increase across all case types. There were 7,277 new cases in FY2020 and 7,143 cases in FY 2021 for a biennium total of **14,420** new cases. Of these, 878 involved COVID-19 as a contributing factor to the complaint or report. Often, these involved questions and concerns surrounding client rights, access to treatment and services, and, sadly, client deaths. OMHDD was also actively involved in systemic advocacy throughout the biennium related to the COVID-19 health emergency, including advocating that the rights of people with disabilities not be unnecessarily and disproportionately affected.

OMHDD continued its work related to the Jensen class action settlement throughout the 2020/2021 biennium. The Jensen case was initiated after OMHDD published a report about the excessive use of restraints in the former Minnesota Extended Treatment Options (METO) program, operated by the Department of Human Services (DHS). In 2012, as part of the settlement of the case, Ombudsman Roberta Opheim and Dr. Colleen Wieck of the Governor's Council on Developmental Disabilities (GCDD) were designated by the Federal Court as advisors to the Court and all parties to the lawsuit. The Ombudsman's role included establishing OMHDD as an as ex officio member of the Olmstead Subcabinet, created by the Governor to help develop, implement, and direct the activities of the state's *Olmstead* plan. Court oversight of the Jensen settlement agreement ended in FY 2021; however, as a member of the Olmstead Subcabinet, OMHDD continues to advocate for improved services and programs and more inclusive opportunities and outcomes for clients.

The FY20/FY 21 biennium also saw the launch of the *Treat People Like People* *(TPLP)* campaign. In collaboration with the GCDD, OMHDD developed *TPLP* to educate key audiences about the abuse and neglect of people with disabilities and how to prevent it; highlight the individuality and value of persons living with a disability, celebrating all aspects of their identity; empower people with disabilities, chemical dependency

issues, and mental illness to understand their rights and when they are being violated; and change the perception of those living with a disability from one of helplessness and vulnerability to equality, appreciation, and respect.

OMHDD implemented a new case management system in FY 2020. Highlights of the new system included improved data tracking and reporting capacity. Additionally, the new system created an option for required Death and Serious Injury reports to be submitted via a webform. Reporters quickly took advantage of the option with 18% of all reports in FY 2020 and 49% of all reports in FY 2021 submitted by webform. Submitting reports via the webform is not only convenient for reporters, but it decreases administrative burden on OMHDD staff.

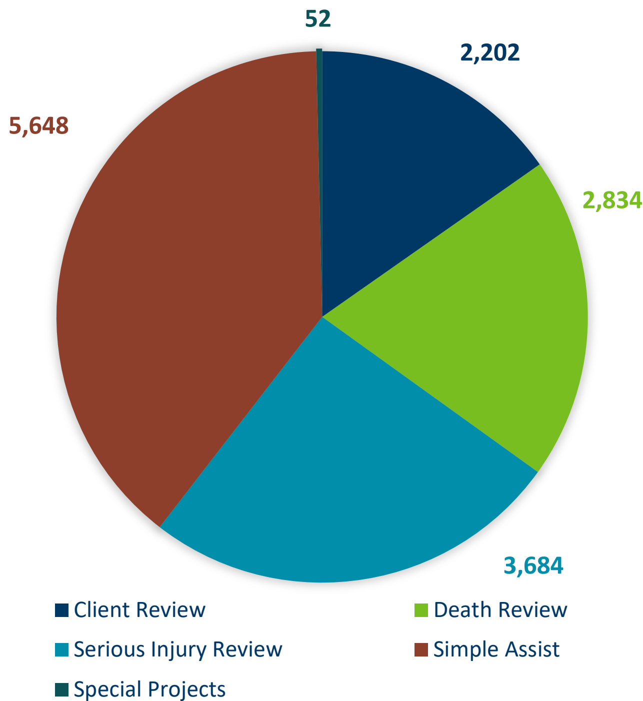


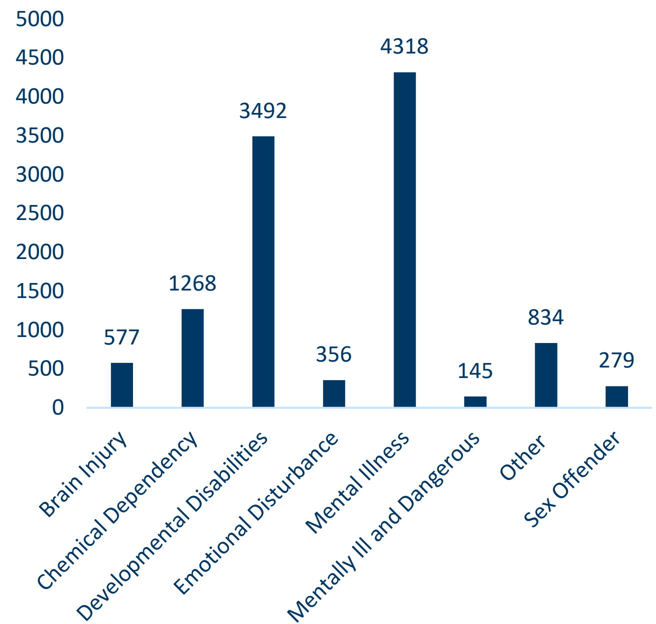
Client Services Overview

The Client Services division of the OMHDD consists of 10 Regional Ombudsmen and one Regional Ombudsman Supervisor. As a result of agency staff retiring and the movement of some Client Services staff into management positions, two Regional Ombudsman positions were hired in this biennium. Due to the COVID-19 pandemic, the entire Client Services team transitioned to telework, while continuing onsite/in-person services when the circumstances warranted. Though some clients expressed a preference for in-person meetings, this transition was seamless and client services were not negatively impacted.

The Client Services team responds to calls and other inquiries from clients, family members, providers, professionals, and other community members who have concerns or questions about services for clients or questions about the laws, rules, or procedures that govern those services. Examples include calls about difficulty accessing services, poor quality services, lack of person-centered approaches, client rights in a variety of residential and other service environments, rights restrictions and rights violations,

guardianship/conservatorship, and service terminations. On these calls, the Regional Ombudsman reviews each situation and determines the most appropriate strategies, suggestions, and level of OMHDD involvement. As always, OMHDD staff strives to provide information, assistance, and advocacy consistent with the highest attainable standards of service for clients in a client-centered, client-driven manner. In this biennium, the Client Services team also responded to 578 requests for assistance involving COVID-19, with 253 in FY 2020 and 325 in FY 2021.





Like all OMHDD cases, Client Services cases occur on a broad continuum of service intensity. Some cases, the Simple Assists, can be resolved relatively quickly with a referral, information sharing that might include a statutory or rule reference, or client self-advocacy strategies and tools that may assist them. These Simple Assists do not reflect that the underlying issue is “simple” by any means, as some can be quite complex, but they are typically completed in a single interaction that can range from a few minutes to an hour or more. Other cases, Client Reviews, are cases that require ongoing OMHDD resources and assistance with Regional Ombudsmen directly involved, involving multiple contacts that may continue for weeks or months, as the circumstances of the case may require.

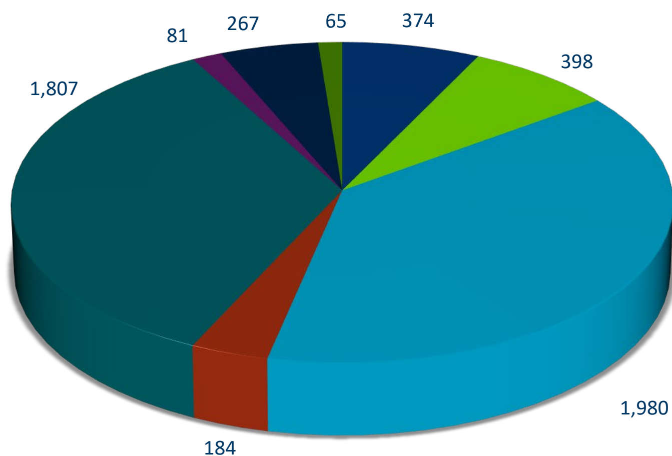
OMHDD provides services to a broad clientele interacting with a wide range of agencies, facilities, and programs delivering their services. Given the diversity of our clients and the service systems with which they interact, the concerns they report to our office, issues that might emerge during a case investigation, and other factors involved in the case, there is great variety in both the types of issues reported to OMHDD and the assistance Regional Ombudsmen may provide to clients, their families, guardians, service providers, and other stakeholders. A single case may involve multiple issues; the most common issues in the FY 20/FY 21 biennium involved client rights, serious injuries, medical issues, social services, and deaths.

ISSUES REPORTED BY TYPE – FY 20/21 BIENNIUM			
Issue	**FY 20**	**FY 21**	**Biennium Total**
Client Rights	2327	1863	4190
Serious Injury (Distinct from Serious Injury Report)	1786	1557	3343
Other/Not Specified	1141	1483	2624
Medical Issues	1536	915	2451
Social Services	1136	608	1744
Death (Distinct from Death Report)	1154	511	1662
Information	792	863	1655
Dignity and Respect	755	482	1237
Guardianship/Conservatorship	681	553	1234
Civil Commitment	565	616	1181
Placement	528	590	1118
Abuse/Neglect/Exploitation	390	459	849
Treatment Issues	421	335	756
Psychotropic Meds	455	234	689
Chemical Dependency	448	211	659
Staff/Professional	288	247	535
Housing	198	249	447
Financial	211	227	438
Referral	168	248	416
Legal	130	186	316
Public Benefits	133	138	271
Data Privacy or Client Records	116	110	226
Restrictions	89	113	225
Insurance	101	86	187
Advance Health Care Directive	23	142	165
Criminal	71	94	165
Child Custody/Protection/Visitation	77	61	138
Employment	59	57	116
Violations of Rule or Law	54	48	102
Managed Care	43	36	79
Transportation	28	20	48
Personal Care Attendant	25	15	40
Education System	16	22	38
Restraint/Seclusion/Rule 40	14	18	32
Training	9	23	32
Legal Representative	10	13	23
ECT	10	4	14
Public Policy	8	6	14
Special Review Board	4	3	7
Special Project Request	5	0	5
TOTAL	**16,002**	**13,446**	**29,448**

The Client Services division also reviews the Serious Injuries required to be reported to OMHDD by agencies and licensed, registered, or certified facilities and programs. Review includes ensuring appropriate medical care was received and necessary actions were/are taken to help prevent injuries where possible. If known or discernable, the Regional Ombudsmen consider the circumstances surrounding the injury and determine if there are potential issues involving abuse or neglect and, if so, ensure any necessary reports were made to the appropriate regulatory entities. As a component of all Serious Injury reviews, including those involving potential abuse and neglect, Regional Ombudsmen make suggestions on possible risk mitigating measures, if any, that might improve client safety and quality of care. OMHDD staff are system monitors, watchdogs, and investigators who determine if more/different services are needed or need to be delivered differently to protect the life, health, safety, and well-being of the clients we serve. The review of Serious Injury reports is a critical component of that role.

SERIOUS INJURY BY CLIENT CATEGORY FOR FY 20/21 BIENNIUM

***Clients may be represented in multiple categories**



- Brain Injury/TBI
- Chemical Dependency
- Developmental Disabilities
- Emotional Disturbance
- Mental Illness
- Mentally Ill and Dangerous
- Other/Not Specified
- Sex Offender

SERIOUS INJURIES REPORTED BY INJURY TYPE FOR FY 20/21 BIENNIUM *Reports may include more than one injury	
Attempted Suicide	317
Complication of Medical Treatment	25
Complication of Previous Injury	38
Concussion, no loss of consciousness	83
Dental Injuries (Avulsion of Teeth)	50
Dislocation	79
Extensive Burns (Second or Third Degree)	59
Eye Injuries	39
Fracture	1517
Extensive Frostbite (Second or Third Degree)	17
Head Injury (with Loss of Consciousness)	106
Heat Exhaustion or Sun Stroke	8
Ingestion of Poison or Harmful Substances	201
Internal Injuries	40
Laceration (with Muscle or Tendon or Nerve Damage)	74
Multiple Fractures	200
Near Drowning	4
Other/Not Specified	349
Other Injury Considered Serious by a Physician or Health Care Professional	278
Potential Closed Head Injury	524
Total	**4,008**

Regional Ombudsmen review all DHS, MDH and MDE investigative findings involving maltreatment allegations; OMHDD may take action based on these notifications. The Regional Ombudsmen also review correction orders issued in licensed settings, Common Entry Point (CEP) notifications, routine survey/complaint survey notifications, and other correspondence submitted to OMHDD. The Client Services team provides trainings and consultations (often referred to as Special Projects) on a variety of issues affecting clients as well as participates in work groups both statewide and regionally. Finally, the Regional Ombudsmen participate in nursing home closures to monitor the process and help ensure a seamless and appropriate person-centered transition occurs for all displaced residents.

NOTIFICATIONS – FY 20/21 BIENNIUM			
Notification Type	**FY 20**	**FY 21**	**Total**
Department of Human Services (DHS) Licensing Maltreatment Investigation Reports	610	593	1203
Office of Health Facility Complaints (OHFC) Reports	63	13	76
Department of Education (MDE) Maltreatment Reports	21	19	40
County Common Entry Point/MAARC	145	242	387
Nursing Home Closures	9	0	9
Total	**848**	**867**	**1,715**

Civil Commitment Training and Resource Center

The OMHDD also houses the Civil Commitment Training and Resource Center (CCTRC). The CCTRC provides training and resources on the civil commitment law, the commitment process, and related issues. This includes formal trainings statewide, fact sheets, notices, and sample hold forms on the OMHDD website. OMHDD also fields calls from clients and others involved in civil commitment procedures, and provides technical assistance to clients, families, counties, providers, and other professionals.

The CCTRC consists of the Regional Ombudsman Supervisor and two Regional Ombudsmen. The CCTRC provided trainings 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. A training focused on forensic commitments is also available. The CCTRC also assists with Crisis Intervention Training (CIT) for law enforcement agencies. These consist of training on the criteria for and use of emergency hold orders.

This biennium, due to a major overhaul of the Minnesota Commitment and Treatment Act, the CCTRC updated its training resources as well as all its fact sheets, notices, and sample hold forms. The CCTRC brochure, notices and fact sheets were also translated into Spanish, Somali, and Hmong and posted to the OMHDD website.

CIVIL COMMITMENT TRAINING AND RESOURCE CENTER TRAININGS – FY 20/21 BIENNIUM						
	FY 20		FY 21			
Training Type	**Trainings**	**People Trained**	**Trainings**	**People Trained**	**Total Trainings for Biennium**	**Total People Trained in Biennium**
Commitment Act	3	129	12	446	15	575
Law Enforcement Crisis Intervention (CIT)	3	77	7	230	10	307
Total	**6**	**206**	**19**	**676**	**25**	**882**

Medical Review Team

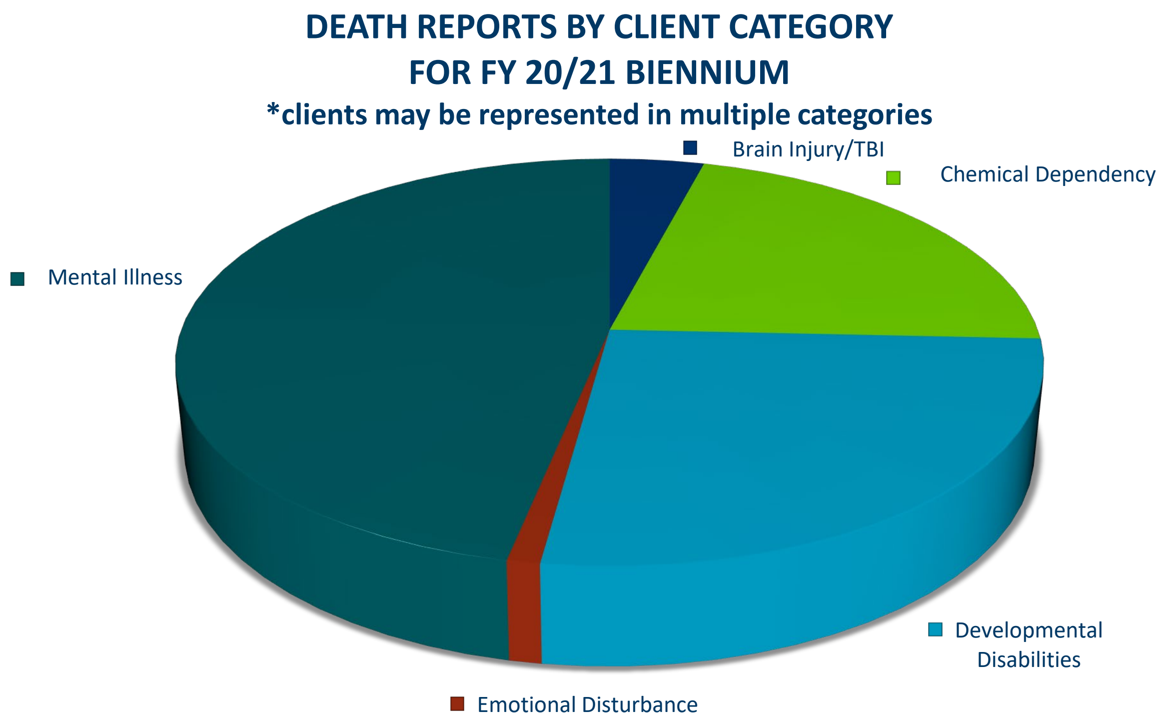
The Medical Review Team serves as a support to the Medical Review Subcommittee, which includes volunteer members of the Ombudsman's Advisory Committee and is empowered under Minn. Stat. 245.97, Sub. 5.

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, 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 when the report is received and again upon its closure.

There were 1,372 deaths reported to the Medical Review Coordinator in FY 2020 and 1,455 deaths reported to the Medical Review Coordinator in FY 2021 for a total of 2,827 death reports during this biennium. During the FY 20/21 biennium, 47% of the death reports were for clients with mental illness, 26% of the reports were for clients with developmental disabilities, and 22% of the reports were for clients with chemical dependency.



During the FY 20/21 biennium, 74% of the deaths reported to the Office of Ombudsman were due to natural causes, with 16% due to accidents, and 7% due to suicide. Of those deaths due to natural causes, 55 reports in FY 2020 and 154 reports in FY 2021 referenced COVID-19 as a cause of death.

CLIENT DEATHS BY MANNER OF DEATH – FY 20/21 BIENNIUM				
Manner of Death	**FY 20**	**FY 21**	**Biennium Total**	**Percentage**
Accident	196	245	441	16%
Blank	0	11	11	<1%
Homicide	15	16	31	1%
Natural	1013	1078	2091	74%
Suicide	116	75	197	7%
Could Not Be Determined	32	28	60	2%
Pending Investigation	0	2	2	<1%
Total	**1,372**	**1,455**	**2,827**	**100%**

Approximately 50% of the deaths reported to the Medical Review Coordinator result in death reviews that are closed after initial review when the information provided is complete. Other death review cases are closed after the collection and review of additional records. Cases receiving further review are either closed after additional review by the Medical Review Team or are brought before the Medical Review Subcommittee for review and, if applicable, formulation of recommendations in an attempt to prevent the recurrence of similar deaths.

Medical Review Subcommittee

The Medical Review Subcommittee typically meets six times each fiscal year. Due to the pandemic, two meetings were cancelled during FY 2020, but processes were developed to allow for remote meetings and the MRS met for all of its six scheduled meetings in FY 2021. During FY 2020, the Medical Review Subcommittee reviewed and closed 19 death reviews, with 24 death reviews reviewed and closed by the Medical Review Subcommittee in FY 2021.

FY 20 MRS MEETINGS	FY 21 MRS MEETINGS
08/09/2019	08/19/2020
10/11/2019	10/09/2020
12/13/2019	12/11/2020
02/14/2020	02/12/2021
	04/09/2021
	06/11/2021

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.
- 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 Alert was created during this biennium:

Clozapine and Constipation, February 2021

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.

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.

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 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, Frostbite 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 http://www.fda.gov/Safety/MedWatch/default.htm.

The Medical Review Team thanks all stakeholders for their interest in and cooperation with the Ombudsman's death reporting process.

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A report issued under the authority of the Ombudsman, Barnett “Bud” Rosenfield

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