MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

2022/2023 Biennium

Report to the Governor

12/17/2025

2022/2023 Biennium Report to the Governor

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Ombudsman's Overview

In the fiscal year (FY) 2022/2023 biennium, the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) celebrated the appointment of a new Ombudsman, Barnett "Bud" Rosenfield in December of 2021. In his announcement, Governor Walz said "I am honored to appoint Bud Rosenfield as the Ombudsman for Mental Health and Developmental Disabilities. Mr. Rosenfield is a dedicated public servant with a proven track record as a passionate advocate for justice. I am confident that he will use his knowledge, experience, and role to create a more just, inclusive, and equitable Minnesota."

The 2022/2023 saw continued growth and demand for OMHDD services, with a 13% increase over the previous biennium. Additional services were added to OMHDD's statutory purview with the implementation of Assisted Living Licensure in FY 22 and the addition of Sober Homes to OMHDD's jurisdiction by the 2023 legislature. 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, substance use disorder, and emotional disturbance as possible throughout fiscal years 2022 and 2023. As expected, contacts continued to increase across all case types. There were 7,829 new cases in FY 2022 and 8,493 cases in FY 2023 for a biennium total of **16,322** new cases.

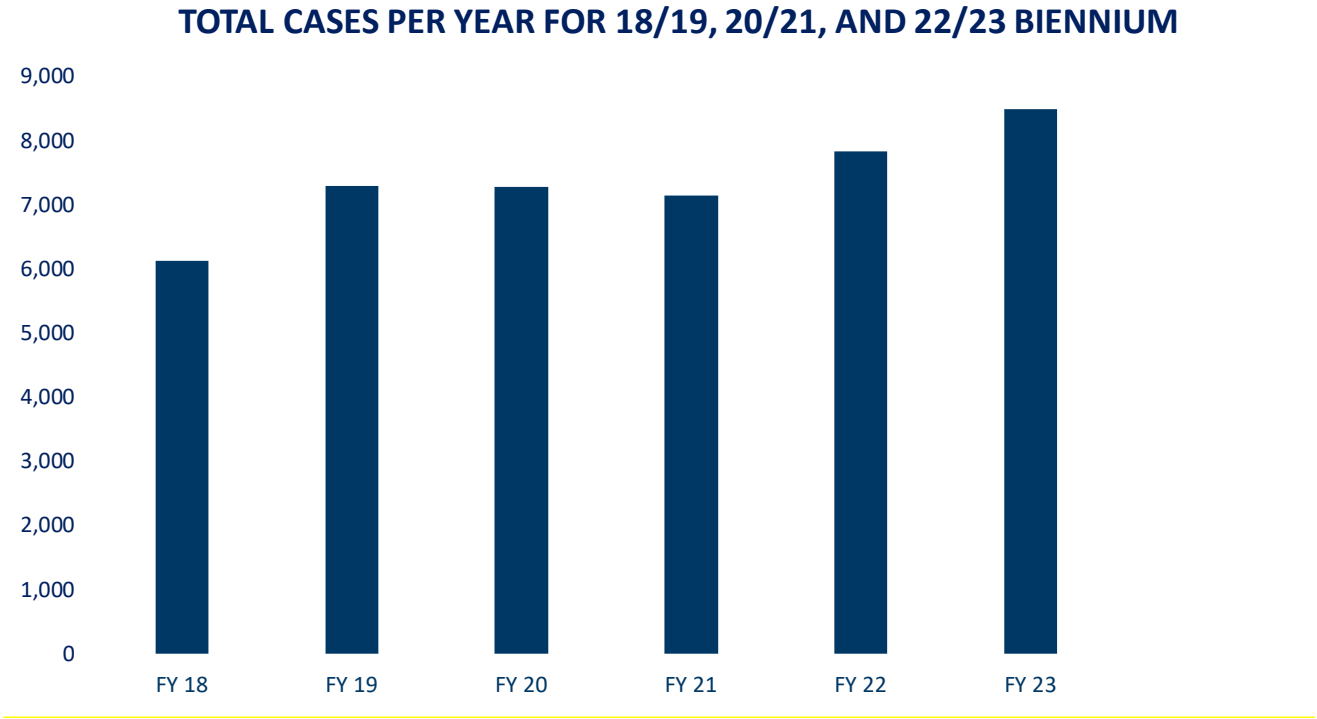
While OMHDD saw an increase in overall case numbers, including death and serious injury reports, the use of the webform to submit reports has also continued to increase. Despite an 18% increase in total reports from the previous biennium, webform submission accounted for 56% of reports for FY 22 and 61% in 2023. The webform is not only more convenient for most reporters, it has allowed OMHDD to maintain administrative staffing capacity at current levels.

In FY 2022, OMHDD initiated a strategic planning process. This work continued into FY 2023 and included gathering feedback from staff throughout the agency, incorporating feedback previously shared by clients and stakeholders, and culminated in a Governor's budget proposal that resulted in an historic increase in agency appropriations. This resulted in four new Regional Ombudsman positions and two Nurse Evaluator positions, expanding agency capacity by 33%.

OMHDD's work on Minnesota's Olmstead Plan continued throughout the FY 22/23 biennium. OMHDD continues to be an 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. OMHDD also serves as a member of the Leadership Forum. During the FY 22/23 biennium, there was much discussion at both the Leadership Forum and the Subcabinet about the plan, culminating in a decision to develop a new Olmstead plan. OMHDD continued to advocate for improved services, informed choice, person-centered planning, more inclusive opportunities, and better outcomes for clients in all our Olmstead work.

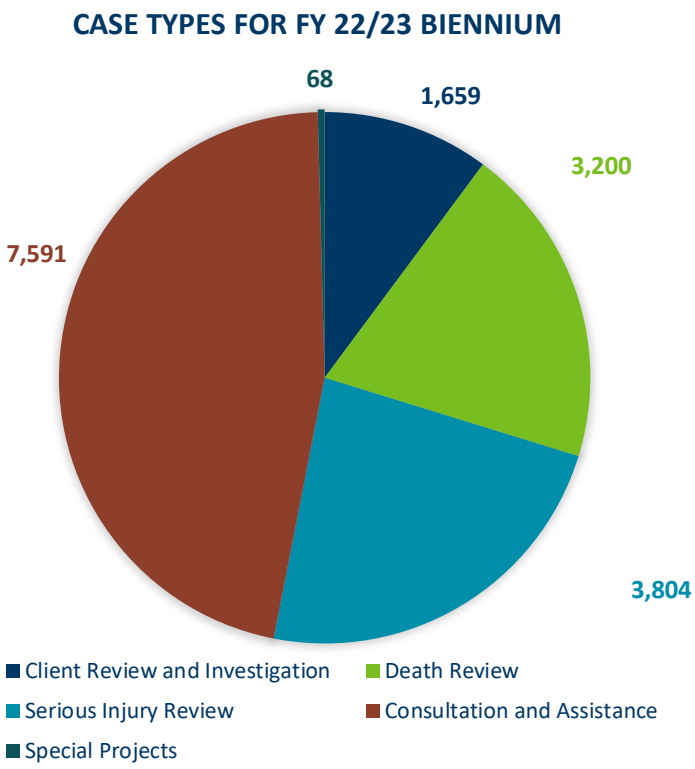
The FY 22/FY 23 biennium also saw the relaunch of the *Treat People Like People (TPLP)* campaign. In collaboration with the Governor's Council on Developmental Disabilities (GCDD), OMHDD developed *TPLP* to educate key audiences about the abuse and neglect of people with disabilities and how to prevent it; highlight the individuality and value of persons living with a disability, celebrating all aspects of their identity; empower people with disabilities, substance use disorder, and mental illness to understand their rights and when they

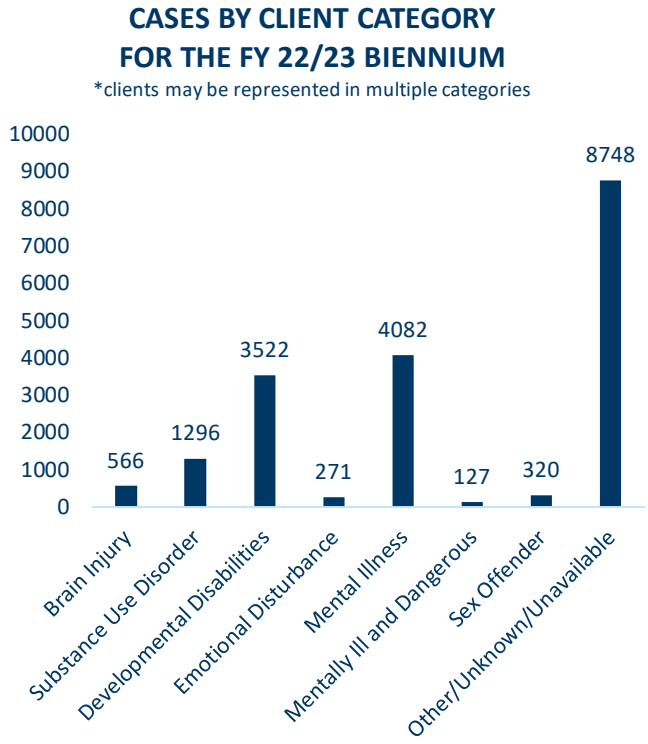
are being violated; and change the perception of those living with a disability from one of helplessness and vulnerability to equality, appreciation, and respect. Throughout the biennium, the Ombudsman provided support to GCDD's efforts in securing ongoing funding necessary to relaunch the campaign, amplify its essential message, and reach as many people as possible.



Client Services Overview

The Client Services division of the OMHDD consists of 10 Regional Ombudsmen and one Regional Ombudsman Supervisor. 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. In these cases, the Regional Ombudsman reviews each situation and determines the most appropriate strategies, suggestions, and level of OMHDD involvement. As always, OMHDD staff strive 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 responded to 13,122 requests for assistance and serious injury reviews, or 80% of all OMHDD cases.





Due to resource and capacity limitations, Client Services cases occur on a broad continuum of service intensity. Some cases, the Individual Consultation and Assistance, 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 Individual Consultation and Assistance cases can be quite complex, but they are typically completed in a single interaction that can range from a few minutes to several hours. Other cases, Client Reviews, are cases that require investigation and/or ongoing OMHDD resources and assistance with Regional Ombudsmen directly involved, involving multiple contacts that may continue for weeks or months or longer, 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, 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. As demand for OMHDD services far exceeds capacity, Regional Ombudsmen prioritize requests for assistance based on several factors including but not limited to statutory priorities, other resources that may be available to assist, the risk of harm or negative consequences to the client as a result of the issue, and how widespread the impact to the client(s) may be. Additionally, a single case may involve multiple issues; the most common issues in the FY 22-23 biennium involved client rights, serious injuries, allegations of abuse/neglect/exploitation, medical

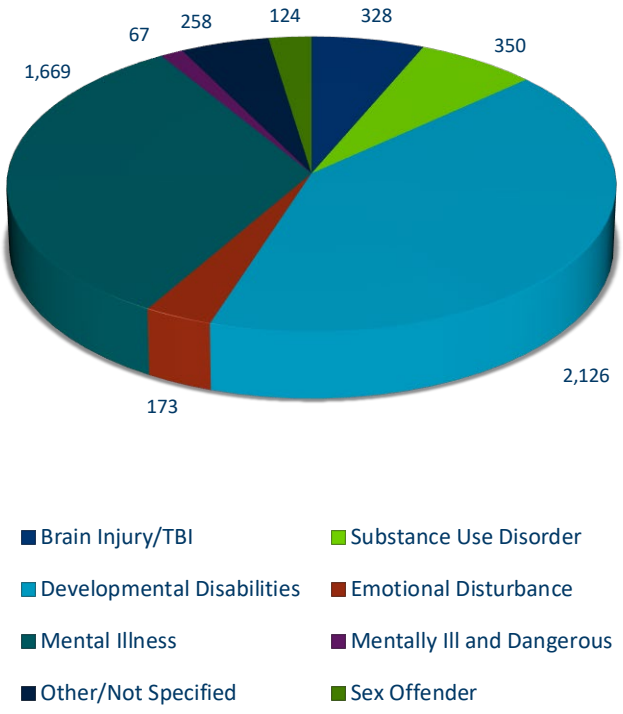
issues, placement concerns, civil commitment, guardianship/conservatorship, social services, and deaths.

ISSUES REPORTED BY TYPE – FY 22/23 BIENNIUM			
Issue	**FY 22**	**FY 23**	**Biennium Total**
Serious Injury (Distinct from Serious Injury Reports)	1,613	1,719	3,332
Client Rights	1,638	1,205	2,843
Information	1,138	1,276	2,414
Death (Distinct from Death Reports)	1,201	614	1,815
Abuse/Neglect/Exploitation	601	787	1,388
Medical Issues	765	545	1,310
Placement	630	526	1,156
Civil Commitment	557	529	1,086
Guardianship/Conservatorship/Rep Payee	511	359	870
Social Services	527	327	854
Other	344	416	760
Referral	366	354	720
Dignity and Respect	793	219	712
Housing	331	341	672
Staff/Professional	282	228	510
Treatment Issues	255	237	492
Legal	228	246	474
Financial	213	187	400
Public Benefits	126	147	273
Criminal	134	134	268
Psychotropic Medications	165	82	247
Advance Health Care Directive	203	30	233
Insurance	117	102	219
Substance Use Disorder	131	83	214
Data Privacy or Client Records	117	96	213
Child Custody/Protection/Visitation	92	100	192
Restrictions	79	105	184
Employment	63	69	132
Violations of Rule or Law	40	35	75
Education System	25	45	70
Transportation	20	287	48
Personal Care Attendant	14	24	38
Managed Care	16	20	36
Training	18	6	24
Legal Representative	10	9	19
Restraint/Seclusion	10	8	18
ECT	7	3	10
Public Policy	2	7	9
TOTAL	**13,082**	**11,248**	**24,330**

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 22/23 BIENNIUM

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



SERIOUS INJURIES REPORTED BY INJURY TYPE FOR FY 22/23 BIENNIUM *Reports may include more than one injury	
Attempted Suicide	405
Complication of Medical Treatment	39
Complication of Previous Injury	44
Concussion, no loss of consciousness	150
Dental Injuries (Avulsion of Teeth)	46
Dislocation	83
Extensive Burns (Second or Third Degree)	69
Eye Injuries	35
Fracture	1500
Extensive Frostbite (Second or Third Degree)	17
Head Injury (with Loss of Consciousness)	96
Heat Exhaustion or Sun Stroke	11
Ingestion of Poison or Harmful Substances	223
Internal Injuries	38
Laceration (with Muscle or Tendon or Nerve Damage)	59
Multiple Fractures	188
Near Drowning	2
Other Injury Considered Serious by a Physician or Health Care Professional	339
Potential Closed Head Injury	841
Total	**4,185**

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 and assisted living closures to monitor the process and help ensure a seamless and appropriate person-centered transition occurs for all displaced residents.

NOTIFICATIONS – FY 22/23 BIENNIUM			
Notification Type	**FY 22**	**FY 23**	**Total**
Department of Human Services (DHS) Licensing Maltreatment Investigation Reports	509	382	891
Office of Health Facility Complaints (OHFC) Reports	176	326	502
Department of Education (MDE) Maltreatment Reports	10	24	34
County Common Entry Point/MAARC	476	600	1076
Nursing Home Closures	10	8	18
Assisted Living Closures	57	99	156
Total	**1238**	**1439**	**2677**

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. OMHDD also translated and posted to our website the CCTRC brochure, client notices, and fact sheets in multiple languages in efforts to reduce barriers to critical client rights information.

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.

CIVIL COMMITMENT TRAINING AND RESOURCE CENTER TRAININGS – FY 22/23 BIENNIUM						
	FY 22		FY 23			
Training Type	**Trainings**	**People Trained**	**Trainings**	**People Trained**	**Total Trainings for Biennium**	**Total People Trained in Biennium**
Commitment Act	12	271	21	524	33	795
Law Enforcement Crisis Intervention (CIT)	7	172	7	187	14	359
Total	**19**	**443**	**28**	**711**	**47**	**1154**

Medical Review Team

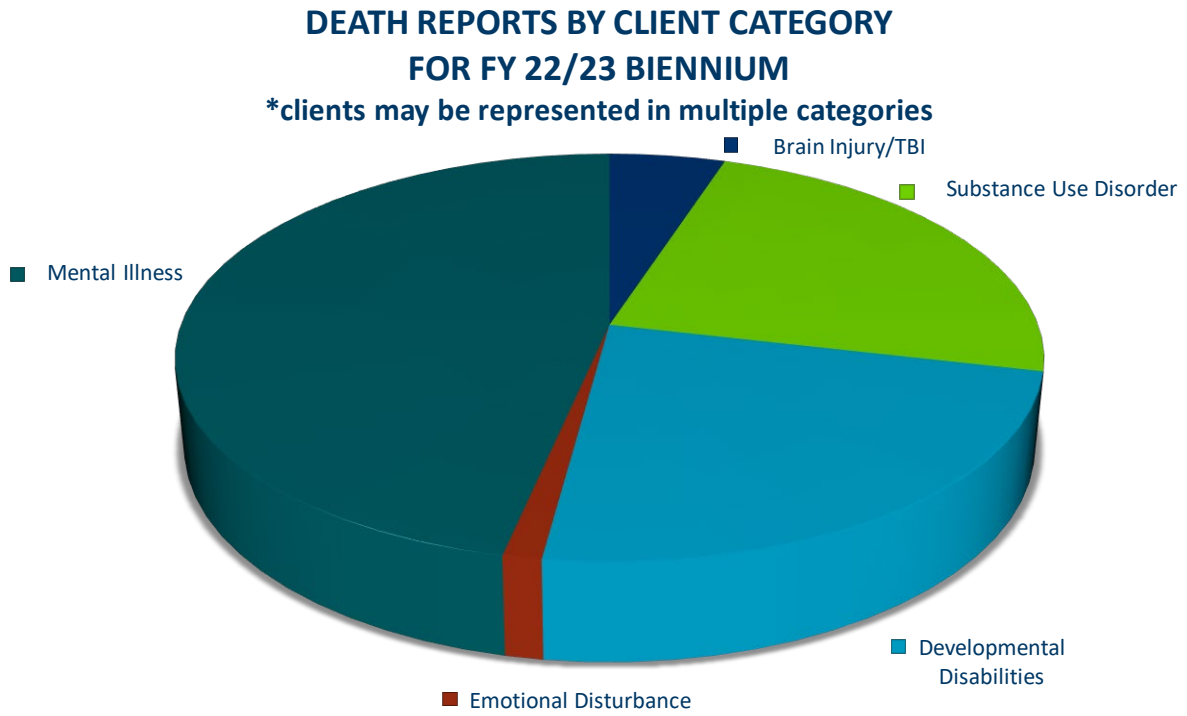
The Medical Review Team serves as a support to the Medical Review Subcommittee, which includes volunteer members of the Ombudsman's Advisory Committee and is empowered under Minn. Stat. 245.97, Sub. 5.

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, substance use disorder, 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 1,585 deaths reported to the Medical Review Coordinator in FY 2022 and 1,615 deaths reported to the Medical Review Coordinator in FY 2023 for a total of 3,200 death reports during this biennium. During the FY 22/23 biennium, 47% of the death reports were for clients with mental illness, 23% of the reports were for clients with developmental disabilities, and 24% of the reports were for clients with substance use disorder.



During the FY 22/23 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.

CLIENT DEATHS BY MANNER OF DEATH – FY 22/23 BIENNIUM				
Manner of Death	**FY 22**	**FY 23**	**Biennium Total**	**Percentage**
Accident	277	356	633	9%
Blank	14	11	25	1%
Homicide	21	9	30	1%
Natural	1,183	1,142	2,325	73%
Suicide	69	68	137	4%
Could Not Be Determined	21	25	46	1%
Pending Investigation	0	4	4	<1%
Total	**1,585**	**1,615**	**3,200**	**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 promote best practices and prevent the recurrence of similar deaths.

Medical Review Subcommittee

The Medical Review Subcommittee (MRS) typically meets six times each fiscal year. Due to the retirements of the former Medical Review Coordinator and Nurse Evaluator in the middle of FY 2023, meetings were paused until a new Medical Review Coordinator could be hired and investigations to refer to the Medical Review Subcommittee resumed.

During FY 2022, the Medical Review Subcommittee reviewed and closed 21 death reviews, with 8 death reviews reviewed and closed by the Medical Review Subcommittee in FY 2023.

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

FY 22 MRS MEETINGS	FY 23 MRS MEETINGS
08/13/2021	08/12/2022
10/08/2021	10/14/2022
12/10/2021	12/09/2022
No Meeting 02/2021	No Meeting 02/2022
04/08/2022	No Meeting 04/2022
06/10/2022	No Meeting 06/2022

- 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 Medical Review Subcommittee 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 informing the public of observed trends in deaths and approaches to remediate common contributors.

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

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2022/2023 Biennium Report to the Governor

A report issued under the authority of the Ombudsman, Lisa Harrison-Hadler,
on behalf of former Ombudsman Barnett "Bud" Rosenfield

The Office of Ombudsman for Mental Health and Developmental Disabilities

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