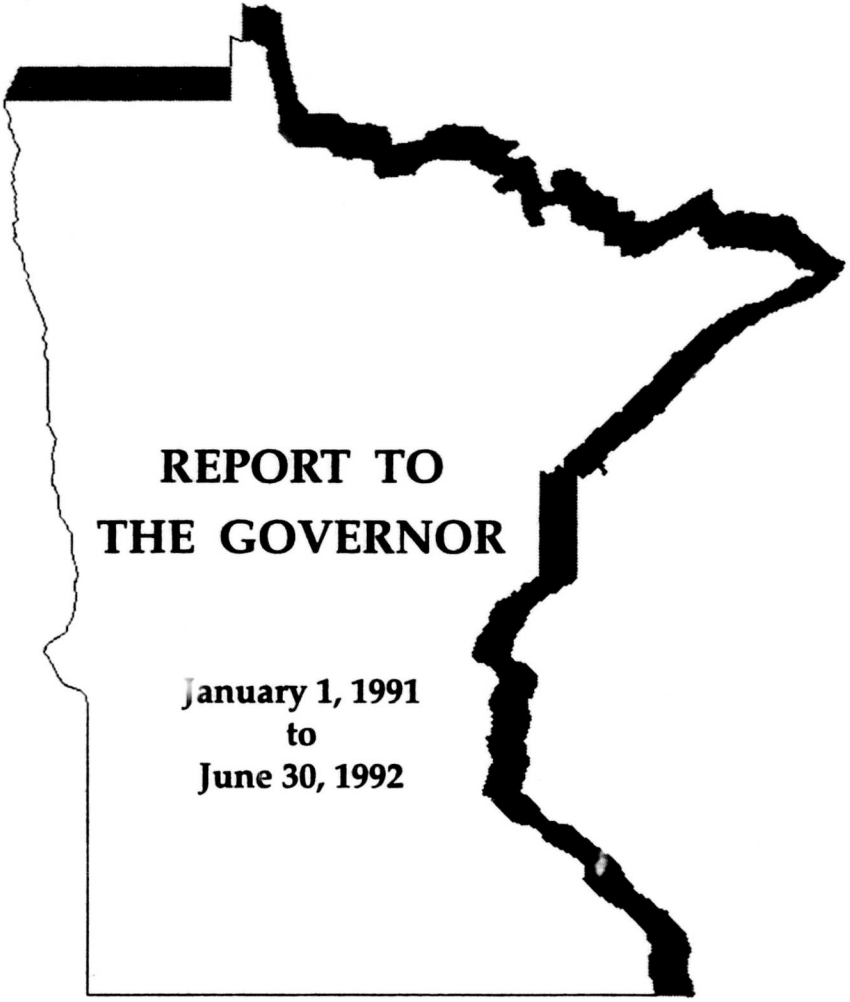
Office of the Ombudsman for Mental Health and Mental Retardation

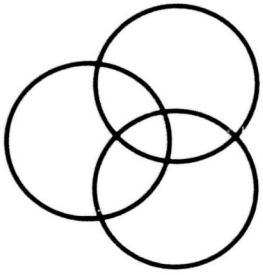


REPORT TO THE GOVERNOR

January 1, 1991
to
June 30, 1992

Submitted by the Ombudsman for Mental Health and Mental Retardation,
Pursuant to Minn. Stat. §245.95, Subd. 2

Contents



Office of the Ombudsman
for Mental Health and Mental Retardation
Suite 202, Metro Square Building
St. Paul, Minnesota 55101

612-296-3848
1-800-657-3506

Mission Statement

The Office of the Ombudsman for Mental Health and Mental Retardation is an independent state agency created under Minnesota Statutes, Sections 245.91 - 245.97 and committed to 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.

The Office seeks to accomplish this mission by:

- Providing direct assistance to individuals when intervention is mandated or necessary to enable them to obtain services meeting the highest attainable standards.

- Intervening through advocacy and mediation on behalf of individuals in disputes and difficulties arising between those individuals, the government, and providers of service.

- Attempting to resolve those disputes and difficulties in ways which are fair and equitable and which reflect respect for the dignity and rights of individuals.

- Identifying, both through the Office's experience in assisting individuals and through its more general investigatory and monitoring activities, systemic problems and issues that affect the adequacy and quality of services delivered to individuals with those special needs.

- Making recommendations to elected officials, agencies of government and providers of services about addressing issues and correcting problems which have the effect of diminishing the standards of treatment, competence, efficiency and justice below the highest attainable.

Introduction

by Bruce H. Johnson

Along with my appointment as Ombudsman for Mental Health and Mental Retardation comes a responsibility to inform those who this Office serves of the direction I expect the agency to take in the coming months. Broadly stated, the Office's mission is to promote the highest attainable standards of care and treatment for the special needs groups which the Office was established to serve.

This is a relatively small agency with a very broad mission. One of my highest priorities has been to initiate a formal process to examine carefully the kinds of things the Office has been doing (or could do) to accomplish its mission and to identify those activities which are most needed or which have the potential to produce the greatest good for the largest number of consumers. One thing has already become quite clear: The Ombudsman's Office needs to be involved as much with system oversight and issues advocacy as it is with individual advocacy, particularly in these times.

Because of pressures on the State and other units of government to do more with less money, this Office, along with everyone else concerned with improving the lives of Minnesotans with special needs, will have to confront some difficult problems and hard choices during the next few years. Many of those problems are likely to be formidable in terms of scope, scale and complexity, but they may also present us with some unique opportunities for positive change.

Relying on our State's tradition of social consciousness and its concern for those in our society who need assistance in reaching their full potential, many Minnesotans have become complacent, even smug, in the belief that we remain at the forefront in offering quality programs and services for the mentally ill, the developmentally disabled, the chemically dependent and the emotionally disturbed. Many of us however, who deal with the system every day have reason to question that premise. The way the State delivers services is something that has evolved by accretion, by agglomeration, and by imposing new sets of requirements on older ones so that there are few unifying threads. Over time the health and social service system has become bewilderingly complex even for experienced professionals; inefficiencies and redundancies have developed, and the system seems dedicated to preserving process rather than to improving the quality of life for people.

Bruce H. Johnson, Ombudsman

As a case in point, studies suggest that Minnesota ranks relatively high in the nation in total monies spent for the developmentally disabled yet ranks relatively low in the amounts spent for actual programming. This means that a great deal of money is being spent in maintaining a delivery system which most would agree is only marginally effective in addressing specific individual needs. This is not just true of our system for providing services for the developmentally disabled; if anything, it is even more true of our system for serving the mentally ill (that is, if what we now have could even be described as a "system").

It is very difficult, particularly in a time of austerity, to muster public support for increased spending on programs for persons with special

needs when we are already spending large sums of money on a delivery system that is not meeting those needs very effectively. In short, I believe that our entire delivery system and the roles which state and local agencies play in it need to be re-examined, and some of the basic premises have to be rethought. When the system is rethought, as appears inevitable, we must ensure that consumer needs, desires and points of view are given careful consideration throughout the process of reform.

As the parents of a developmentally disabled child, my wife and I have never been armed with a great deal of technical knowledge about the system. We have had to be guided in our encounters with it primarily by using a "common sense" test. We constantly find ourselves asking questions like: Why is there virtually no continuity of services and programming when a developmentally disabled person leaves the school system and enters the social service system? Why must we keep digging on our own to try to find all of the possibilities available to him? Why do people within the system keep talking in terms of the programs into which he might fit rather than asking him what his personal needs and desires are and trying to work from there? All of these questions have brought the common sense test into play, and by and large the system has failed that test primarily because of a great deal of fragmentation and a point of view that is process-centered and not consumer-centered.

A first step toward a consumer-centered system might be a fresh look at the way in which programs are designed. As discomforting as the proposition may be, funding does drive programs. Since we appear to be entering an era of dwindling financial resources, this is even more likely to be true in the future. What this fact of life should do is emphasize the importance of finding ways to use the money available for programs more wisely and effectively than we have in the past. This means reassessing how funding programs are designed and configured.

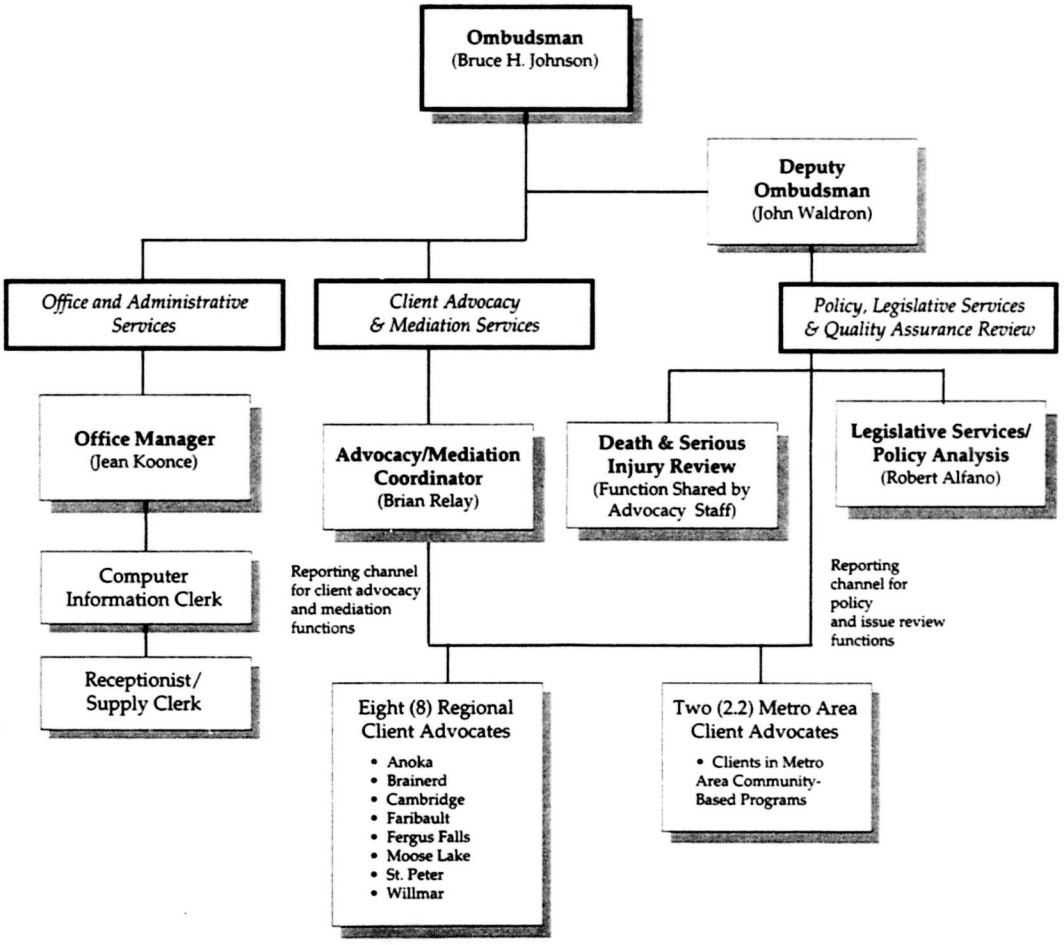
The past practice seems to have been for government to design funded programs as a rigidly-defined set of program eligibility requirements and required fund uses that are geared to the averages or norms for the targeted special needs groups—in effect, a series of round holes into which individuals (as "square pegs") must be forced. There has rarely been much thought about how much the expenditure of those funds is really improving individual lives.

In order for programs to be responsive to individual needs, there has to be a way of measuring "outcomes"—in other words, determining whether the funds have been expended in ways that have improved the quality of life for people in the real world and helped them realize their full potential as valued and contributing members of the community. While I am encouraged by the efforts currently underway to place more emphasis on outcomes, I am concerned that for reasons of administrative convenience outcomes will end up being defined solely in terms of "objective standards" and, thus, merely become a new (perhaps more sophisticated) set of holes into which individuals must be forced.

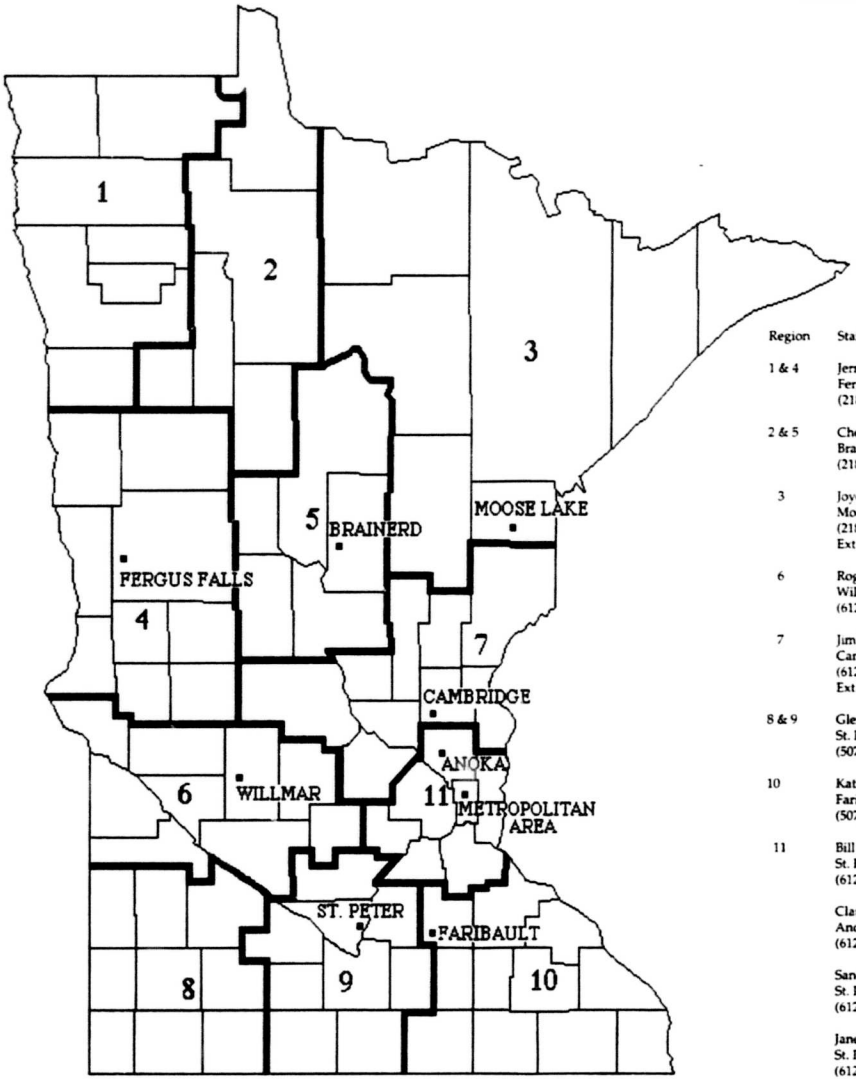
There has to be a recognition by program managers that a good "outcome" is an individual event and involves quality of life issues which cannot always be measured quantitatively. I am not unmindful of the difficulties which subjective assessment poses for program managers or the need for objective standards for ensuring that money is spent in the way intended. But program design should at least involve a better balance between meeting individualized personal needs, on the one hand, and administrative convenience and the need for accountability, on the other.

Economic necessity is driving government to change. The way programs for Minnesotans with special needs are designed and managed is only one of many areas that can profitably be re-examined. The main challenge for all of us in the months and years ahead is to ensure that the changes that come are focused on the parts of the system that are not working and not on those that are. It is my intention that the Office of the Ombudsman for Mental Health and Mental Retardation will be deeply involved in the process of change and that it will become a place where consumers and those who support and represent consumers can have their views heard during this process of governmental reform.

Ombudsman Organizational Chart



Ombudsman Regional Offices



Region	Staff
1 & 4	Jerry Hanson Fergus Falls RTC (218) 739-7364
2 & 5	Cheryl Turcotte Brainerd RTC (218) 828-2366
3	Joyce Hultberg Moose Lake RTC (218) 485-4411 Ext. 302
6	Roger Schwab Willmar RTC (612) 231-5962
7	Jim Tausch Cambridge RTC (612) 689-2121 Ext. 337
8 & 9	Glenda Bode St. Peter RTC (507) 931-7105
10	Kathleen Dohmeier Faribault RTC (507) 332-3380
11	Bill Wyss St. Paul Office (612) 297-2762
	Claudia Hulleman Anoka RTC (612) 422-4269
	Sandra Newbauer St. Paul Office (612) 296-5687
	Jane Brink St. Paul Office (612) 297-7853
	Toll-Free Number 1-800-657-3506

NOTE: Although the offices of the regional client advocates are located in the regional treatment centers, staff also responds to complaints from the communities.

Ombudsman Advisory Committee

Overview

By Kevin Cedergren, Chair

The Ombudsman Advisory Committee consists of 15 members appointed by the governor to staggered three-year terms. The Committee is comprised of providers, consumers, and advocates in the areas of mental health, chemical dependency, emotional disturbance and developmental disabilities. We serve to assist and advise the Ombudsman Office in enhancing services provided in Minnesota. A subgroup of our committee serves the Ombudsman in medical review. Additionally this year, our members may assist Office staff in specific studies, response reviews and assignments. There is much to be proud of in Minnesota's services, but there is much more to learn. Our Committee is dedicated to assisting in the achievement and maintenance of a preeminent position for Minnesota in the field of human services delivery.

Committee Members

In 1991, the Ombudsman Advisory Committee consisted of the following members:

Member:	Appointment Date:
Gary Berg	Januar / 1990
Dr. John Bergstrom	Apr. 1990
Kevin Cedergren, Chair	Ma / 1991
James Dahlquist	Janua y 1990
Rebecca Fink	Janua y 1989
Melvin Goldberg	Janu ry 1990
Dr. Carl Hansen	Janu ry 1989
Marilyn Kaplan	M ay 1991
Genevieve Jilk O'Grady	Janu. ry 1989
Dr. Jennifer Olson	M ıy 1991
Rodney Otterness	Janua.y 1990
Kathleen O'Brien	January 1989
Terry Schneider	January 1990
Dorothy Skarnulis	January 1990
Dr. Lindsey Thomas	May 1991
James Tweedy	May 1991

For 1992, the Ombudsman Advisory Committee will consist of:

Gary Berg
Kevin Cedergren
James Dahlquist
*Dr. George Dorsey**
Melvin Goldberg
Marilyn Kaplan
*Jane Klingle**
Dr. Jennifer Olson
*Scott Roberg**
Terry Schneider
*Lori Squire**

(2 Vacancies to be filled late summer)

** Newly appointed members*

The Ombudsman Office wishes to thank the following individuals who have served as Committee Members:

Dr. John Bergstrom
Louise Brown
Barbara Case
Dr. Carl Hansen
Kathleen O'Brien
Genevieve O'Grady
Dr. Lindsey Thomas
James Tweedy
Dr. Ruth Viste

Medical and Clinical Review Function

The Ombudsman Medical Review Subcommittee (MRS) is in its fifth year of reviewing the causes and circumstances surrounding the deaths of clients who were receiving services or treatment for mental illness, developmental disability, chemical dependency, or emotional disturbance. During this time over six hundred deaths have been reported to the Office and over 400 of these have been reviewed by the MRS.

Evaluation of the quality of care that the client was receiving is the primary function of the MRS. In their review, the MRS determines if there was any failure in the care provided to the client. The MRS then evaluates to what extent, if any, the failure in care might have contributed to the client's death. Recommendations on improving the quality of care and reducing the likelihood of a similar client death from occurring are made by the MRS to the Ombudsman. Special attention is given to client deaths by suicide, accident, or those deaths that are undetermined. The MRS meets on a regular basis and works closely with Ombudsman staff and providers of client services in an effort to improve the quality of client care.

In summary, the Medical Review Subcommittee has played an active role in helping to promote the highest attainable standards of treatment, competency, efficiency, and justice for clients. The future holds many challenges for the MRS in its effort to continuously improve the quality of medical and clinical care provided clients.

Members of the MRS for 1991 were:

- Dr. Carl Hanson, MD, Chair
- Dr. John Bergstrom, MD
- Kevin Cedergren
- Rebecca Fink
- Melvin Goldberg
- Dr. Jennifer Olson, MD
- Dr. Lindsey Thomas, MD
- James Tweedy

Members of the MRS for 1992 are:

- *Dr. George Dorsey, Chair*
- *Kevin Cedergren*
- *Melvin Goldberg*
- *Dr. Jennifer Olson, MD*
- *Lori Squire*

Ombudsman Medical Review Function to be Revised

We are currently revising our medical review process to create a more effective method of analyzing data and reviewing and investigating client deaths. Emphasis will be on analyzing the aggregate of data we collect along with individual care review. We believe that the strengths of this approach will be: that the aggregate of data will lead to identifying patterns and trends; and that the analysis of the aggregate of data will assist us in identifying and addressing systemic problems.

Our data collection system will be revised to collect pertinent data related to the deaths. For example, deficiencies in the care provided the client, such as delays in assessing lab reports, multiple or poly pharmacy, failure of medical equipment, and lack of or ineffective policies or procedures.

In collecting the aggregate of data, we will be able to identify patterns which might indicate system-wide problems. In those cases, further research or investigation will likely take place, and most important, corrective action will be implemented by the Medical Review Subcommittee and the Ombudsman. For example, questions can be raised and the data queried to ascertain whether persons with disabilities are more likely to die because of bowel obstruction than other consumers or the normal population.

Individual case review of a death will be limited to only those deaths in which significant cause exists to review and investigate the death, i.e. suicides, deaths of children, deaths caused by medication or medication errors, etc. These deaths will be investigated by the Ombudsman staff to determine if there are underlying patterns that might indicate systemic issues. Also, these deaths will be referred for further action to appropriate licensing or oversight agencies such as the Office of Health Facility Complaints, the Board of Medical Examiners or the Board of Nursing.

Finally, emphasis will be on providing the public, consumers, and providers with information that can be of help in improving quality of care. This will take on many different forms such as reports, position papers, conferences, etc. We want to provide an atmosphere in which cooperation is primary and information is shared, discussed, and improvement in the quality of services is made.

Advocacy and Mediation Activities

Since its creation in July, 1987, the Ombudsman Office has received well over 11,000 complaints from consumers and other sources concerning the care and treatment of persons with mental illness, developmental disabilities, chemical dependency, and emotional disturbance. The majority of these complaints, approximately 52%, deal with a variety of issues on the care and treatment of persons with mental illness. Another 36% deal with developmental disabilities; 8% with chemical dependency, and about 5% with children and adolescents with emotional disturbance.

From January 1, 1991 to December 31, 1991, the Office handled 2,519 complaints. Of these, 1,300 dealt with persons receiving services for mental illness; 857 dealt with persons receiving services for developmental disabilities; 207 for persons with chemical dependency; and, 155 for children or adolescents with emotional disturbance.

Mental Illness

The types of complaints received by or on behalf of persons with mental illness range from issues with discharge to issues concerning invasive therapeutic treatment. Often the complaints received dealt with restrictions of all types (movement, seclusion/restraints, money, phone, mail, visitors) which made up about 18% of all the complaints concerning the care and treatment of persons with mental illness. Another area of issues received (about 7%) dealt with the commitment process: emergency holds, due process, lack of adequate legal representation, etc. Issues with treatment or program plans made up about 8% of the complaints; these included such issues as denial of certain types of treatment, inappropriate treatment, treatment plans or programs that are not addressed to meet the individual needs of the consumer. Medication issues (neuroleptics and psychotropics) made up another 8% of the complaints received. Generally, the medication issues involved the Treatment Review Panel at the Regional Treatment Centers and Jarvis Hearings.

Developmental Disabilities

In contrast to complaints concerning the care and treatment of persons with mental illness, complaints received by or on behalf of persons with developmental disabilities fell into two major areas: issues with discharge (19.5%) and treatment or program plans (21%). Issues with discharge dealt primarily with consumers being discharged from less restrictive settings or community programs to more restrictive settings such as Regional Treatment Centers or ICF-MRs. Treatment or program plans generally dealt with issues around lack of appropriate programming, lack of Individual Service Plans (ISPs), or denial of services or programs. Another area of concern was with issues of abuse and neglect of consumers receiving services or programs for developmental disabilities; these issues made up 8.5% of the complaints received.

Chemical Dependency

Of the 207 complaints received by or on behalf of consumers with chemical dependency, 13% were issues with discharge; 11% with funding; and, 10% with treatment or program plans. The issues with discharge, unlike those received on persons with developmental disabilities, dealt mainly with unwanted discharge (demission) from a chemical dependency program (that is "kicked out" of treatment). Funding issues concerned the level of funding, un-

der Rule 25, provided by the county for chemical dependency treatment. Generally these issues involved inadequate funding for treatment programs, often the consumer was faced with out-patient treatment instead of more intensive inpatient treatment. Treatment or program plans were issues that covered a wide range of concerns by the consumer, from too intensive therapy to cultural and ethnic biases.

Emotional Disturbance

Eighteen percent of the 155 complaints received by or on behalf of children or adolescents with emotional disturbance involved issues with treatment or program plans. These were primarily issues over vague and non-individualized treatment or program plans which lead to increased length of stays for emotionally disturbed children or adolescents in residential programs. Restrictions of all types made up another 17% of the complaints received regarding consumers with emotional disturbance. Of these issues, close to half involved the use of seclusion or restraints (these came primarily from residential Rule 5 facilities). Issues involving discharge (10%) dealt with long length of stays and the consumer wanting to be discharged to home or less restrictive setting (foster care, group home, etc.). Abuse and neglect issues were also of concern making up 10% of the complaints.

Systemic/Focused Reviews

As stated in the introduction to this report, the Office is re-evaluating its approach to systems issues, and is striving to become more involved with this advocacy function in the future.

Examples of the Office's 1991 Systemic Reviews included:

Warning to Facilities about Neuroleptic Malignant Syndrome

The Ombudsman Office Medical Review Subcommittee (MRS) reviewed cases of client deaths resulting from Neuroleptic Malignant Syndrome (NMS). NMS is a potentially fatal drug-induced disorder that can affect persons who are receiving antipsychotic drug treatment. While it is a relatively rare disorder, its need for prompt medical diagnosis and treatment, make it crucial that facility staff are aware of the disorder. In its review, the MRS found that in the cases reviewed, earlier diagnosis of NMS may have saved client lives. Based on these findings, the Ombudsman recommended that facilities hold inservice trainings on NMS, and that written protocols be developed for early detection and management.

Client Injuries on Special Transportation Services

In the course of reviewing serious injuries that had been reported to the Office, it was found that an unusually high number of injuries were sustained while the client was utilizing special transportation services. These services include motor vehicle transportation provided on a regular basis designed primarily to serve individuals who are handicapped or disabled and who are unable to use regular means of transportation. In response, the Ombudsman recommended that Developmental Achievement Centers (DAC's) and Rule 34 and Rule 36 facilities review their client safety and supervision procedures. The Ombudsman called for comprehensive in-service training sessions on transportation safety, including basic safety and emergency intervention and client supervision procedures.

Quality of Care at Faribault Regional Center

Based on several complaints regarding the quality of care and programming at Faribault Regional Center (FRC), the Ombudsman Office conducted a comprehensive review of client services from January through April 1991. The review included unannounced visits by Office staff to FRC units suspected of abuse; interviews with FRC administrative, professional, and supervisory staff; interviews with the Rice County Attorney's Office, the Department of Human Services, Rice County Social Services, Faribault Law Enforcement, and client representatives; review and evaluation of client incident reports, and review and evaluation of FRC policies and procedures. Thirty-one (31) specific findings pointed to three major conclusions: FRC administration condoned facility wide practices that had created an intimidating environment to staff who are mandated to report cases of suspected abuse and neglect; FRC administration had failed to evaluate and take effective corrective action on identified incidents and situations impacting on the safety and well being of clients; FRC administration had failed to insure that clients receive active and appropriate programming at FRC. The Ombudsman made twenty-one specific recommendations regarding these findings, basically urging FRC to improve its quality of services to clients. The Office, through both individual client advocacy and on-going monitoring, is continuing to promote the highest standards of treatment care and programming for clients at FRC.

Strategic Planning

A major activity of the Office this year has been the development and implementation of a strategic plan. Office staff with the help of the Department of Administration's Management Analysis Division created a strategic document that assists us in planning for the future. The strategic plan will help us develop and implement new strategies in working with consumers and providers in assessing quality services as cost effectively as possible.

This planning process included all staff. We reexamined and reevaluated our agency structure; developed an over all vision for our agency; assessed the obstacles and barriers that will impact on reaching our mission; and, we developed strategies and implementation plans to help reach our mission.

The vision we created for our agency is: (1) a unified and effective operation, and (2) better quality of life for clients. In reaching this vision, we decided we needed to develop several strategies as follows:

- create a harmonious workplace;
- increase staff competencies;
- develop creative and effective use of resources;
- develop processes for quality improvement;
- develop a mission and agency philosophy;
- develop methods for public policy impact;
- collaborate with other agencies;
- insure client-focused services.

We have been very busy working on the implementation of our strategic plan. This work is done through self-directed work groups made up of various staff which are assigned projects to complete. These work groups meet frequently and develop overall plans of actions, including milestones and deadlines in reaching their goal. The following is a partial list of the work groups we now have assigned to several projects:

- Mission Statement
- Data Privacy
- Retention and destruction of Agency records
- Revision of the Agency Medical Review function
- Revised and upgrade agency Data Collection System
- Create library services
- Annual training plan for staff training
- Revise Agency Advocacy function
- Review of MI/CD delivery services
- Systemic-issues, including monitoring of information, etc.

In addition, the Ombudsman Advisory Committee is also in the process of defining its mission as it relates to the Office.

The Office realizes it faces many challenges in the future. By taking an active approach to planning, we hope to be able to meet these challenges by providing client centered and quality services.

Ombudsman Activities

The time period of January 1, 1991 to June 30, 1992, saw many changes and activities in the Ombudsman Office.

In November 1991, Shirley Hokanson stepped down as the state's first Ombudsman for Mental Health and Mental Retardation. In accepting her resignation, Governor Carlson recognized Ombudsman Hokanson by stating that she had "served as a sensitive, intelligent, caring person," and that he appreciated her contribution to public service. In December, Governor Carlson appointed Bruce H. Johnson, formerly the director of the Office of Health Facility Complaints as the new Ombudsman.

The Office has undertaken many activities in the eight months since Ombudsman Johnson's appointment. Work soon began on the development of a strategic plan to help the Office develop and implement new strategies to assess quality services, and to develop a more harmonious and effective work place. The Office also developed a new mission statement (which is at the front of this report) to help the agency accomplish its broad mandate of attaining the highest standards of care and treatment for the special needs groups the office serves.

The Office's system of data collection was reevaluated and redesigned. This required new hardware and software and a redesign program that allows staff to concurrently review and evaluate data by the following methods:

- evaluate the aggregate of data by the causes of system breakdown;
- evaluate the aggregate of data by the type of services the clients were receiving;
- evaluate the aggregate of data by the actions taken and the outcome reached by staff on the complaint;
- evaluate the aggregate of data by type of disability and diagnosis;
- evaluate the aggregate of data by demographics, such as gender and ethnic background of clients;
- generate reports by correlations of data;
- generate reports by the sampling of data by inquiry

These methods and the data collected will give the office a rich source of information for identifying system-wide problems in the delivery of services and programs to clients.

On June 25, 1992, the Office hosted its first annual Ombudsman Awards Banquet. The purpose of the awards program is to recognize services that have been innovative and those that have positively impacted current treatment areas in the categories of mental health, developmental disabilities, chemical dependency or emotional disturbance. In April, the Ombudsman Office solicited nominations for programs that were based on the following criteria: innovation, quality of care and services, client or consumer satisfaction, and enhancement of quality of lives. Nearly 70 responses were received by the May 15 deadline. Office staff visited each site to review the program, and a selection committee comprised of advisory committee members and staff rated all nominated programs. Programs were rated according to innovation in delivery of services, ability to provide a wide range of consumer choices, impact on transforming the way in which service needs were met; and also in providing flexibility and creativity in the delivery of services.

1992 Ombudsman Awards for Excellence Winners

Mental Health Services

- *Sibley County Community Support Program*
- *Range Mental Health Community Support Program*
- *Twenty-Sixth Street Artists, Minneapolis*

Honorable Mention: Camp Gandir

Chemical Dependency Services

- *Four Winds Lodge, Brainerd Regional Human Services Center*
- *Vinland Chemical Health Programs*
- *Rebuild Resources, Inc.*

Emotional Disturbance Services

- *PATH: Family Foster Treatment for Children*

Honorable Mention: Project CAASEY

Diverse Services

- *Project Challenge, School District 742, St. Cloud*

Developmental Disabilities Services

- *Cambridge Pre-Admission and Evaluation Project*
- *Rum River Ornamental Products and Services of Cambridge RHSC*
- *Southside Services of Minneapolis*
- *People First Advocacy of Olmstead County*

Honorable Mentions: Crossroads Day Training and Habilitation Program of Willmar

Distinguished Service Award

- *Anne Henry, Developmental Disability Law Project*

1987 - 1992 Ombudsman Office in Review

July 1, 1987: Office of Ombudsman created under MS 245.91.

September 1987: Former State Representative Shirley Hokanson appointed first Ombudsman.

October 1987: First meeting of the Ombudsman Advisory Committee is held.

October 1987: Mass mailing to 676 facilities and agencies informing them of the existence of the Office.

November 1987: First meeting of the Ombudsman Medical Review Subcommittee.

December 1987: Public meetings are held throughout the State to give providers information on the operation of the Ombudsman Office.

December 1987: The Ombudsman Office finds home at the Metro Square Building, St. Paul.

January 1988: The Medical Review Subcommittee (MRS) establishes procedure for the review and investigation of client deaths.

January 1988: Active legislative session for the Office in which the duties of the Court Monitor under Welsch are transferred to the Ombudsman.

May 1988: Office develops policy/action plan which includes legislative initiatives for subpoena power for the Ombudsman; definition of serious injury to clients; and, mandates 24 hour reporting to the Office of serious injuries and deaths of clients.

October 1988: First Ombudsman Newsletter is published.

December 1988: Medical Review Coordinator position established. The Medical Review Coordinator is responsible for the medical/clinical review function of the Office.

January 1989: Ombudsman legislative initiatives approved by legislature Office begins implementation of review and investigations of serious injuries and deaths to clients under the new mandated reporting law.

January 1989: First Annual Report by the Ombudsman is published.

May 1989: Ombudsman Office releases report on the use psychotropic medication with developmentally disabled clients in community residential programs.

October 1989: Ombudsman Office releases public report on Gerard of Minnesota regarding the quality of care for emotionally disturbed children at Gerard.

January 1990: Ombudsman Office assists with drafting legislative language that controls and prohibits certain restrictive techniques and procedures with emotionally disturbed children in residential programs.

April 1990: Ombudsman Advisory Committee releases report on Case Management services in the state of Minnesota.

December 1990: Ombudsman Office releases public report on the delivery of services to emotionally disturbed children in Rule 5 residential programs.

April 1991: Ombudsman Office releases public report on the Quality of Care at Faribault Regional Center (FRC).

November 1991: Shirley Hokanson steps down as Ombudsman.

December 1991: Bruce H. Johnson, Director of Office of Health Facility Complaints, appointed Ombudsman.

January 1992: Office begins reorganization and strategic planning.

February 1992: Office, with assistance of the Management Analysis Division, completes strategic plan and begins implementation of the plan.

May 1992: Office of Ombudsman mission statement completed.

June 1992: New data collection system developed.

June 1992: Office implements policy and procedures on review and assessment of system-wide issues impacting consumers of services.

June 1992: Ombudsman Awards program attended by over 200 people.

Ombudsman Minn. Stat. §245.91

I. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION STATUTE: MINN. STAT. § 245.91-.97

245.91 DEFINITIONS.

Subdivision 1. **Applicability** For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state departments of human services and health, and of designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 3. **Client.** "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services, and an acute care inpatient facility that provides services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 5. **Regional center.** "Regional center" means a regional center as defined in section 253B.02, subdivision 18.

Subd. 6. **Serious Injury.** "Serious injury" means:

(1) fractures;
(2) dislocations;
(3) evidence of internal injuries;
(4) head injuries with loss of consciousness;
(5) lacerations involving injuries to tendons or organs, and those for which complications are present;
(6) extensive second degree or third degree burns, and other burns for which complications are present;
(7) extensive second degree or third degree frost bite, and others for which complications are present;
(8) irreversible mobility or avulsion of teeth;
(9) injuries to the eyeball;
(10) ingestion of foreign substances and objects that are harmful;
(11) near drowning;
(12) heat exhaustion or sunstroke; and
(13) all other injuries considered serious by a physician.

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility, or

program. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff**. The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota state retirement association.

Subd. 2. **Advocacy**. The function of mental health and mental retardation client advocacy in the department of human services is transferred to the office of ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation**. The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers**. (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, mental retardation or a related condition, or emotional disturbance.

(f) The ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(g) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(h) The ombudsman may attend department of human services review board and special

review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the department of human services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(i) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 12 and 13, regarding services provided to clients with mental retardation or a related condition.

(j) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(k) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. **Matters appropriate for review**. (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

(1) may be contrary to law or rule;

(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

(3) may be mistaken in law or arbitrary in the ascertainment of facts;

(4) may be unclear or inadequately explained, when reasons should have been revealed;

(5) may result in abuse or neglect of a person receiving treatment;

(6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(9) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Subd. 2a. **Mandatory Reporting.** Within 24 hours after a client suffers death or serious injury, the facility or program director shall notify the ombudsman of the death or serious injury.

Subd. 3. **Complaints.** The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (c), against a client or other person, who in good faith makes a complaint or assists in an investigation.

Subd. 4. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(l) consider the matter further;

(2) modify or cancel its actions;

(3) alter a rule, order, or internal policy;

(4) explain more fully the action in question; or

(5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. **Specific reports.** The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

Subd. 2. **General reports.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall at the end of each year report to the governor concerning the exercise of the ombudsman's functions during the preceding year.

245.96 CIVIL ACTIONS.

The ombudsman and his designees are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. **Membership**. The ombudsman committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. **Compensation; chair**. Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. **Meetings**. The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. **Duties**. The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. **Medical review subcommittee**. At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are

governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(l) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

Subd. 6. **Terms, compensation, removal and expiration**. The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1993.