State of Minnesota
The Office of Ombudsman for Mental Health and Developmental Disabilities
2012/2013 Biennium Report to the Governor

Ombudsman's Overview

A New Era with New Challenges

The 2012/2013 Biennium began with a new challenge for the workload of the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) that dramatically affected this small agency. The Ombudsman and her staff began doing work related to two Federal Class Action law-suits involving individuals who are clients of the OMHDD. The defend-ant in the lawsuits was the Department of Human Services (DHS), as an agent of the State of Minnesota.

At the beginning of the Fiscal Year 2012, the OMHDD became involved in what is known as the Jensen Settlement Agreement. The settlement agreement was the result of a Class Action lawsuit which was initiated after the OMHDD published a report in 2008 about the excessive use of restraints in the Minnesota Extended Treatment Program (METO). See the report here: http://www.mn.gov/mnddc/meto_settlement/index.html The agreement and information about the agreement can be found on the Governor's Council on Developmental Disabilities web site at http://www.mn.gov/mnddc/meto_settlement/index.html. The settlement provided compensation for those who had been subjected to restraints as well as requiring the state to make systemic improvements for individuals with developmental disabilities. The agreement included a prohibition on the use of mechanical restraints for individuals with developmental disabilities and only allowed for the use of manual restraints in an emergency situation. It also mandated the state to develop an Olmstead plan based on the US Supreme Court's 1999 decision that ruled people may not be kept in an institution simply because less restrictive alternatives do not exist.

Due to the lack of progress by the DHS in implementing the Jensen settlement agreement, in July 2012 Federal Judge Donovan Frank ordered the appointment of a court monitor. The court monitor appointed was David Ferleger, an attorney from Pennsylvania. In addition, the judge designated Ombudsman Roberta Opheim from the OMHDD and Dr. Colleen Wieck, Executive Director of the Governor's Council on Developmental Disabilities as consultants to the court and all parties.

This assignment greatly increased the work of the OMHDD. There were frequent and ongoing meetings to attend and thousands of pages of documents to review and provide comment on. Regional Ombudsmen assisted the Ombudsman in specific client cases that resulted from the Jensen Settlement Agreement.

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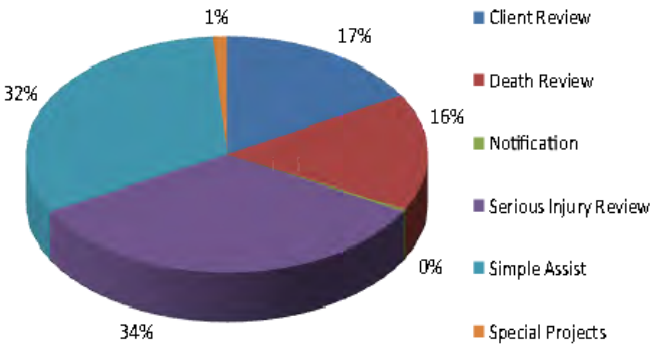
In the 2012/2013 biennium, there was a change in assignments for the regional staff. The Serious Injury Reports that had been reviewed by the Medical Review Unit (MRU) were reassigned to the regional staff due to loss of staff within the MRU. This change allowed for more timely and thorough review of the reports. This constituted a major shift in work as there were 2,877 Serious Injury Reports received in the biennium. Some of the reports included more than one injury. Some of these reviews only require review of the information received but the majority require contact with the provider to get more

The issues with the greatest number of contacts were serious injuries, medical issues and client rights.

Cases By Type Of Issue	FY 2012	FY 2013	Biennium Total	Percentage (%)
Abuse/Neglect/Exploitation	204	219	423	2.04
Advance Directive	8	8	16	0.08
Chemical Dependancy	157	225	382	1.84
Child Custody/Protection/Visitation	35	47	82	0.40
Civil Commitment	318	402	720	3.47
Client Rights	903	1,294	2,197	10.58
Criminal	48	83	131	0.63
Data Privacy/Client Records	61	65	126	0.61
Death	655	718	1,373	6.61
Dignity and Respect	552	729	1,281	6.17
ECT	562	744	1,306	6.29
Education System	14	26	40	0.19
Employment	25	50	75	0.36
Financial	103	136	239	1.15
Guardianship/Conservatorship/Rep Payee	552	729	1,281	6.17
Housing	105	168	273	1.32
Information	321	357	678	3.27
Insurance	62	89	151	0.73
Legal	117	175	292	1.41
Legal Representative	5	10	15	0.07
Managed Care	16	22	38	0.18
Medical Issues	767	973	1,740	8.38
Other Contacts	469	522	991	4.77
Personal Care Attendant	18	16	34	0.16
Placement	356	381	737	3.55
Psychotropic Meds	209	285	494	2.38
Public Benefits	110	161	271	1.31
Public Policy	16	14	30	0.14
Referral	21	58	79	0.38
Restraint/Seclsuion/Rule 40	35	21	56	0.27
Restrictions	81	78	159	0.77
Serious Injury	1,392	1,485	2,877	13.86
Social Services	472	627	1,099	5.29
Special Project Request	1	0	1	0.00
Special Review Board	2	1	3	0.01
Staff/Professional	202	201	403	1.94
Training	8	7	15	0.07
Transportation	15	22	37	0.18
Treatment Issues	276	275	551	2.65
Violations of Rule or Law	26	35	61	0.29
Total	**9,299**	**11,458**	**20,757**	**100.0**

Information. The reviews can also lead to the regional staff making suggestions regarding medical attention or treatment plans to address issues.

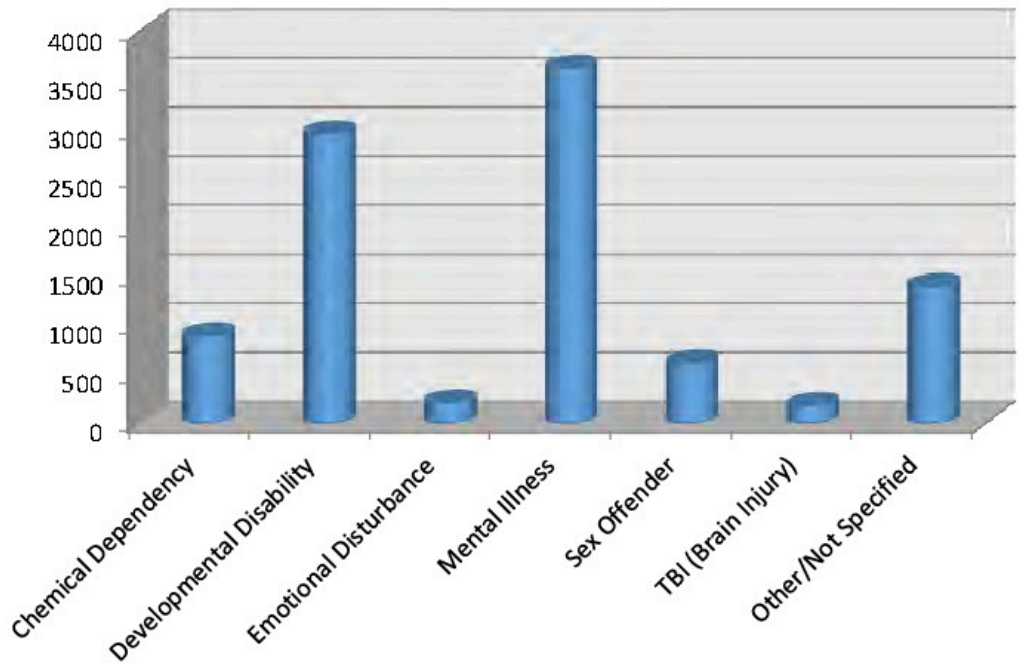


Following Serious Injury Reports, the next highest number of cases the staff worked on were medical issues. The medical issues most often pertain to medical needs the client may have that are not being addressed or the client's wishes not adequately being considered. The regional staff will then review the situation and work with either the team or provider to help ensure these needs are addressed.

Client rights/treatment provision issues continue to be issues frequently addressed by the OMHDD. Many times clients feel powerless to advocate with providers when they feel their rights are being restricted. Restrictions may be put in place in an effort to protect the individual but the restrictions are not always necessary as there may be less restrictive options available. The OMHDD considers rights issues a high priority.

Civil commitment contacts may be from anyone seeking information or technical advice on the MN Civil Commitment and Treatment Act.

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



The OMHDD has also seen an increase in contacts from other state agencies.

With the OMHDD housing the Civil Commitment Training and Resource Center, its staff is trained on the civil commitment law and how to work with clients on this issue. Examples of these cases would be to work with the treatment team or the county pre-petition screening team on less restrictive options the client may be willing to participate in but were overlooked, trying to clarify comments the client made but were misinterpreted, or looking into whether or not the laws were followed. Many times the client will call in an attempt to avoid commitment.

The OMHDD is receiving a marked increase in contacts regarding placement concerns. The concerns include: termination of services without adequate notice, lack of appropriate placement options and placement closures. These issues often lead to otherwise unnecessary hospitalizations, crisis bed usage, lack of client choice for housing and placement failure due to lack of individualized placement considerations or service provision.

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

The majority of the cases the regional ombudsman staff receive are of two types. One is a simple assist and the second is a client review. A simple assist is a case where the issue can be handled more quickly by giving the person requested information or advising on how they can proceed. This can involve researching the issue first. It can also include a case where the OMHDD has no authority to act so the regional ombudsman refers to an agency or group that can assist. The majority of cases handled by OMHDD's regional ombudsman are simple assists.

A client review is a case in which the staff is much more involved. The OMHDD has noticed that client review cases are becoming much more complex than in past years. The regional ombudsman are attending more staff meetings and doing more in-depth reviews of issues, both of which take more time to complete due to the complexity of the case or issue.

The OMHDD also receives notifications from other agencies that are not included in the charts/ data. The OMHDD receives maltreatment investigation reports from the Department of Human Services Licensing Division, MN. Department of Health and Department of Education. **The OMHDD received 1,087 reports in the 2012/2013 biennium**. The staff and management review these findings. In some cases the OMHDD will ask to have the findings reconsidered if it believes the findings were not based on the definitions in statute. These may also lead a regional staff to get involved with the treatment team due to concerns related to the provision of care.

Ombudsman Specialist for Peer Services	Totals
PCP Presentations (2 days each)	45
Persons Attended	875

The OMHDD also receives notifications from the Department of Human Services regarding Special review Board hearings being scheduled and the recommendations from the hearing. **The OMHDD received 491 of these notifications in the biennium**. These are reviewed by the Regional Ombudsman Supervisor and two regional staff who work with the state run forensic programs. Some of these lead to more involvement by other OMHDD staff.

In this biennium, the OMHDD also added a new position to Client Services, the Ombudsman Specialist for Peer Services (OSPS). This position was developed to gather information for agency clients as to services they need from the OMHDD and the mental health system. The OSPS meets with clients and others involved in the provision of services to look at issues that need to be addressed in the system and to look at how the OMHDD can better provide assistance. The OSPS also received certification to provide training on Person Centered Treatment and has provided 45 presentations (two days each) to approximately 875 people. Those attending are people involved in developing treatment plans for service recipients.

The OMHDD also provides systemic monitoring and training in addition to individual case work.

System Notifications	Total
MDH, DHS, MDE Maltreatment and Licensing	1087
DHS Special Review Board	491
Total	1,578

Medical Review Unit

Total number of reported deaths for the this Biennium was 1,377.

This total of deaths compares with 1,259 deaths reported in the previous Biennium.

The Medical Review Unit (MRU) started the biennium, July 2011 through June 2013, with three staff members: the Medical Review Coordinator, a part-time nurse evaluator, and a part-time reviewer for serious injuries. The MRU serves as a support to the Medical Review Subcommittee, (MRS) 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 MRS has a quality-improvement focus, and, by statute, avoids duplication of the work of agencies such as DHS - Licensing and the Office of Health Facilities Complaints, which perform detailed investigations and have sanction authority. If the MRU finds a situation that needs that type of investigation, referrals are made to the appropriate agencies or licensing boards. The MRU works collaboratively with other agencies or boards but avoids duplication of their work.

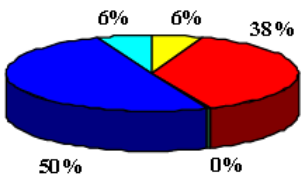
Death Reports

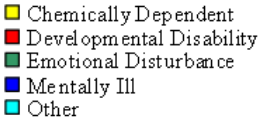
Both the Ombudsman and the Regional Ombudsman are notified of each death report when the report is received and again upon its closure. There were 658 deaths reported to the Medical Review Coordinator in FY 2012 and 719 deaths reported to the Medical Review Coordinator in FY 2013. This total of 1,377 deaths is higher than the total of 1,259 deaths reported during the 2010/2011 biennium but lower than the total of 1,456 deaths reported during the 2008/2009 biennium.

Many death reports are closed by the Medical Review Coordinator upon receipt when the information provided is complete or after the collection and review of additional records. Other cases are reassigned for further review by the part-time nursing evaluator. Cases receiving further review are either closed after additional review by the MRU or are brought

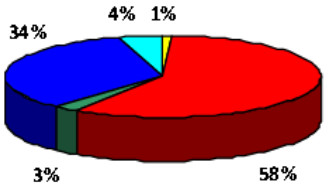
These pie charts represent the Deaths and Serious Injuries reported in this Biennium.

Deaths by Disability for Biennium





Serious Injuries by Disability for Biennium



Manner of Death	FY 2012	FY 2013	Biennium Total	Percentage (%)
Accident	82	89	171	12
Homicide	5	2	7	1
Natural	522	572	1,094	79
Suicide	30	38	68	5
Undetermined	19	18	37	3
Total	**658**	**719**	**1,377**	**100**

before the MRS for its review and for the formulation of recommendations to prevent the recurrence of similar deaths.

The MRS met six times during FY 2012 and six times during FY 2013 to review the deaths and serious injuries of clients that met its established guidelines. During FY 2012, the MRS reviewed and closed 45 death reviews. During FY 2013, the MRS reviewed and closed 48 death reviews.

While seeking opportunities to improve the care delivery system, the MRS looks at not only individual cases but also for patterns and trends. When it identifies patterns or trends, the MRS 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 Alerts and Educational Information opportunities were created or updated during the 2012/2013 biennium and remain available on the Ombudsman's website: http://mn.gov/omhdd/documents/medical-alerts.jsp.

- Breathing Alert
- Choking is a Medical Emergency
- Delay of Treatment
- Immunization Alert
- Reporting Medications (Key to Client Safety)
- Use of over-the-counter medications and possible delay of treatment
- Advocating for your clients with health care providers -A PowerPoint presentation from the OMHDD's MRU
- Suicide Prevention Resource List

Serious Injury Reports

There were 2,925 serious injuries reported during the 2012/2013 biennium. This compares with 2,829 serious injuries reported during the 2010/2011 biennium and 3,251 serious injuries reported during the 2008/2009 biennium. During the 2012/2013 biennium, 667 serious injury reports were received that were classified as "Other". Most of those reports were instances of clients who either required medical evaluations for medical illnesses or conditions or for incidents of choking.

Until October 1, 2011, most serious injury reports were closed upon initial review by the Medical Review Coordinator. The remaining serious injury reports were assigned for further review to the Regional Ombudsman. Both the Ombudsman and the Regional Ombudsman were notified of serious injury.

Medical Alerts are available on the website: http://www. ombudmhdd.state.mn.us/alerts/default.html

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

reports in his or her region both when a report was received and again upon its closure.

After October 1, 2011, serious injury reports were immediately assigned on intake to the Regional Ombudsman for review and closure. The Medical Review Coordinator, the part-time nurse evaluator, and the Medical Review Subcommittee remain available to the Regional Ombudsmen for consultation on individual reviews. The Ombudsman, the Regional Ombudsman Supervisor, and the Medical Review Coordinator continue to be notified of serious injury reports when the reports are closed.

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

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

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

The MRU thanks you for your cooperation with the Ombudsman's death and serious injury reporting process.

Type of Serious Injury	FY 2012	FY 2013	Biennium Total	Percentage (%)
Burns (second or third degree)	60	58	118	4
Complications of Medical Treatment	21	24	45	2
Complications of Previous Injury	7	18	25	1
Dental Injuries (avulsion of teeth)	29	13	42	1
Dislocation	12	10	22	1
Eye Injuries	14	12	26	1
Fracture	653	655	1,308	45
Frostbite (second or third degree)	1	0	1	0
Head Injury (with loss of consiousness)	38	40	78	3
Heat Exhaustion/Sun Stroke	4	2	6	0
Ingestion of Poison or Harmful Substances	44	41	85	3
Internal Injuries	14	8	22	1
Laceration (muscle/tendon/nerve damage)	29	42	71	2
Multiple Fractures	73	68	141	5
Near Drowning	1	3	4	0
Other	384	488	872	30
Suicide Attempt	26	33	59	2
Total	**1,410**	**1,515**	**2,925**	**100**

Equal Opportunity Statement

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

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

Civil Commitment Training and Resource Center

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

In the 2012/2013 biennium, the Civil Commitment Training and Resource Center (CCTRC), a part of The Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) provided training on the Civil Commitment and Treatment Act to county social workers, county attorneys, defense attorneys, nurses, psychiatrists, psychologists, hospital social workers and other mental health providers. The CCTRC also participates in crisis intervention training for law enforcement and emergency personnel. The CCTRC provided 25 trainings to approximately 900 individuals. These trainings cover the commitment process from the initial screening, commitment hearing and discharge requirements. The CCTRC is continuing to receive requests for training on civil commitment.

In addition to training activities, the CCTRC also responds to questions on the commitment process. These questions come from clients, county social services, county attorneys, defense attorneys, examiners, court personnel, treatment facility staff, and families.

The CCTRC also prepares an annual summary of the legislative changes to the commitment statutes to send out to professionals dealing with the act and to post on the OMHDD website.

The CCTRC also updates the notices that the OMHDD is legislatively mandated to develop. These notices are required to be given to persons who are going through the commitment process by the county pre-petition screeners. In addition to this, the OMHDD also maintains fact sheets on the commitment process for anyone to use.

The CCTRC also receives many individual calls for assistance with technical questions. These are usually specific to individual cases that are unusual for a county or have a difficult situation involved on which a county would like a non-legal opinion. The CCTRC also receives many calls from clients related to the commitment process.

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The second class action case was filed by individuals being served in the Minnesota Sex Offender Program (MSOP) asking the Federal Court to declare that program to be unconstitutional. As part of that court process the court hired four experts from around the country to do an evaluation of the program.

Federal Court Judge Donovan Frank was appointed to this case. Judge Frank appointed a Blue Ribbon Task Force led by former Chief Judge of the Minnesota Supreme Court Eric Magnuson. Ombudsman Opheim was appointed as a member of the task force. The Sex Offender Civil Commitment Advisory Task Force's charge was to study the Minnesota's use of Civil Commitment to commit and treat sex offenders and make recommendations for change and improvement. Recommendations of the task force can be found at http://mn.gov/dhs/general-public/about-dhs/advisory-councils-task-forces/sex-offender-task-force.jsp.

This process included more meetings and documents for the Ombudsman to review. It also added to the OMHDD's workload as increased contacts were generated from the MSOP clients. As this case continued through its process, the OMHDD monitored clients who were hopeful for a positive outcome to their claim.

Rounding out the biennium was the work of developing a new Ombudsman data collection system and the migration of data from one system to another. As can be predicted, this IT project involved massive amounts of detail and the implementation did not go smoothly. As such, the data presented in this report was gathered from two separate data collection programs.

Despite the increased workload from these projects, the staff of the agency continued to provide a high level of service for clients who sought assistance with their cases. Minnesota residents can continue to rely upon the services of the Office of the Ombudsman for Mental Health and Developmental Disabilities.

OMHDD Mission Statement

Promoting the highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

State of Minnesota

The Office of Ombudsman for Mental Health and Developmental Disabilities

2012/2013 Biennium Report to the Governor

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

The Office of Ombudsman for Mental Health and Developmental Disabilities

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