2018/2019 Biennium

Report to the Governor

07/27/2022

2018/2019 Biennium Report to the Governor

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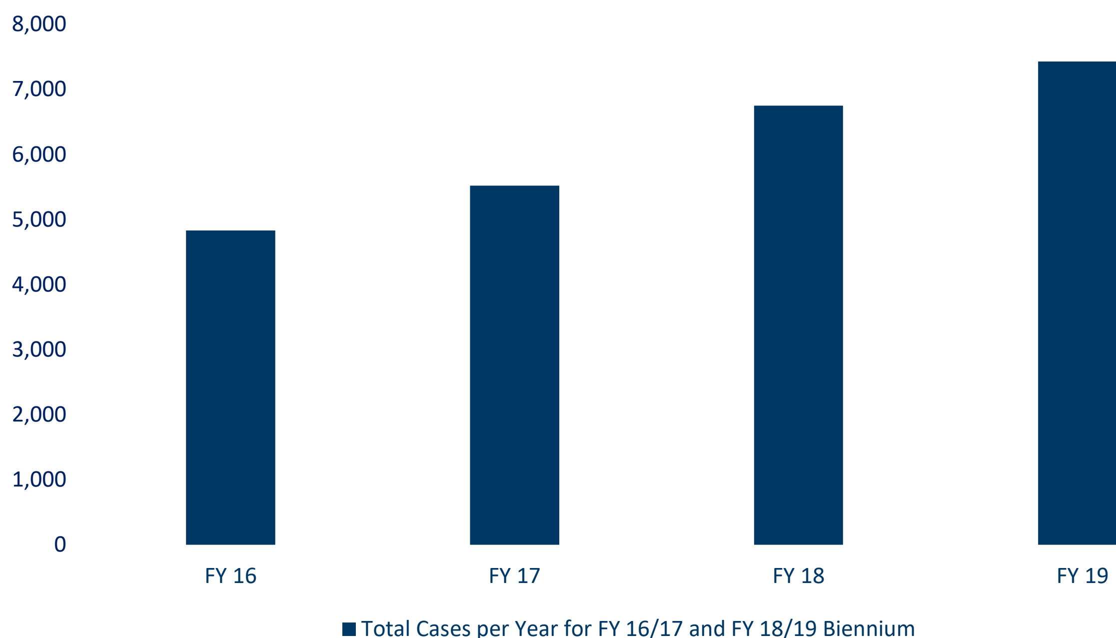
Ombudsman's Overview

The 2018/2019 biennium saw continued growth in the OMHDD's work. Statutory changes passed in the 2017 legislative session impacted the agency by expanding the OMHDD's reach beyond licensed facilities to include registered and certified settings. This allowed OMHDD staff to more broadly address and respond to concerns for clients receiving similar types of services regardless of the regulatory structure of their particular service setting.

The OMHDD also continued its work on the Jensen class action settlement (Jensen case) during the 2018/2019 biennium. The Jensen case was initiated after the OMHDD published a report about the excessive use of restraints in the Minnesota Extended Treatment Options (METO) program, operated by the Department of Human Services (DHS). In 2012, as part of the settlement of the case, Ombudsman Roberta Opheim and Dr. Colleen Wieck of the Governor's Council on Developmental Disabilities (GCDD) were designated by the federal court as advisors to the court and all parties to the lawsuit. In subsequent years, the Ombudsman's role was to help advise the Court and the parties on various aspects of the settlement. This included the development and implementation of the Positive Supports Rule. It also included inclusion OMHDD as an as ex officio on the Olmstead Sub-cabinet, created by the Governor to help develop, implement, and direct the activities of the state's *Olmstead* plan. As a member agency of the *Olmstead* subcabinet, the OMHDD continued throughout FY18/19 to advocate for improved services and programs and more inclusive outcomes and inclusion opportunities for clients.

With the agency's scope of work expanding, staff in all areas of the OMHDD have continued to deliver accurate, effective, and timely agency assistance to as many of Minnesota's residents receiving services for mental illness, developmental disabilities, chemical dependency and children with emotional disturbance as possible. As expected, contacts and client cases continued to increase in the FY 18/FY 19 biennium across all case types. There were 6,751 new cases in FY18 and 7,431 cases in FY 19, for a biennium total of **14,182** new cases. In FY 18, with death reports increasing, the Medical Review Unit added a staff person to assist with increased volume. Similarly, in FY 19, the OMHDD added a full-time Regional Ombudsman (RO) to improve the agency's capacity to respond to the steadily growing number of contacts and Serious Injury reports received.

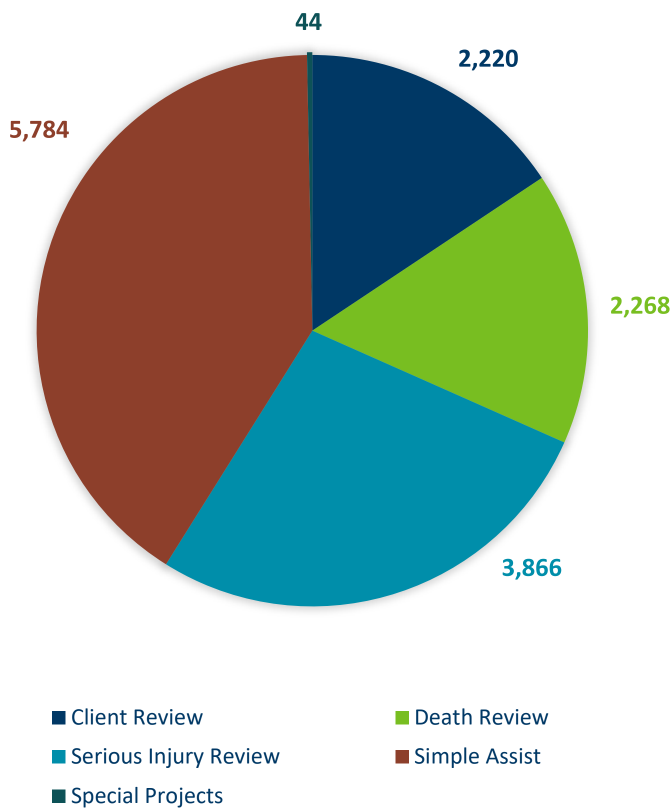
The FY18/19 biennium also saw the OMHDD's development of a significant new project, the *Treat People Like People (TPLP)* campaign. In collaboration with the GCDD, the OMHDD developed *TPLP* to educate key audiences about the abuse and neglect of people with disabilities and how to prevent it; highlight the individuality and value of persons living with a disability, celebrating all aspects of their identity; empower people with disabilities, chemical dependency issues, and mental illness to understand their rights and when they are being violated; and change the perception of those living with a disability from one of helplessness and vulnerability to equality, appreciation, and respect.

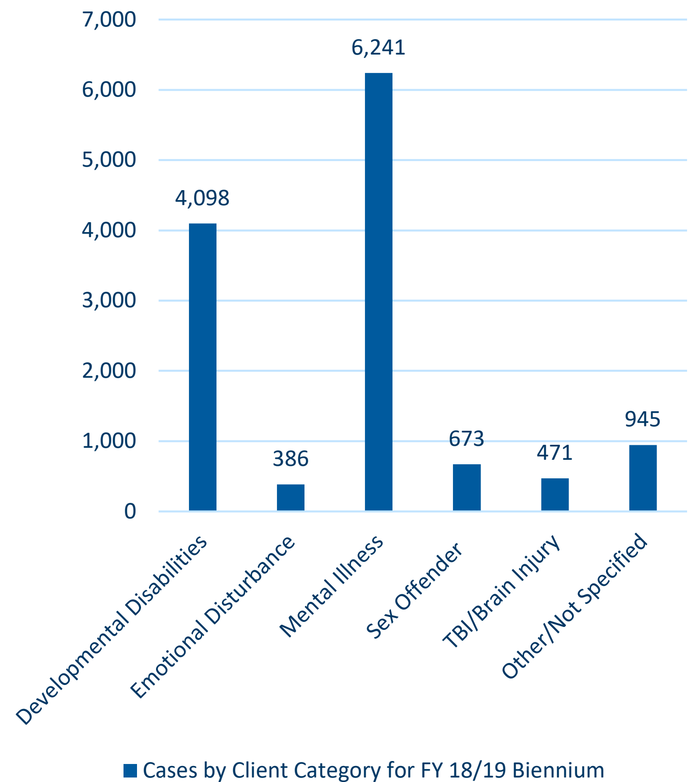


Client Services Overview

The Client Services division of the OMHDD consisted of nine Regional Ombudsman and one Regional Ombudsman Supervisor in FY 2018. As noted above, in January 2019, the OMHDD added a Regional Ombudsman position to help cover the metro area due to a steady increase in the number of metro area cases. As such, the Client Services team grew to ten Regional Ombudsmen, plus a Regional Ombudsman Supervisor, in the FY18/FY19 biennium.

The Client Services team responds to calls and other inquiries from clients, family members, providers, professionals, and other community members who have concerns or questions about services for clients or questions about the laws, rules, or procedures that govern those services. Examples include calls about difficulty accessing services, poor quality services, lack of person-centered approaches, client rights in a variety of residential and other service environments, rights restrictions and rights violations, guardianship/conservatorship, and service terminations. On these calls, the Regional Ombudsman reviews each situation and determines the most appropriate strategies, suggestions, and level of OMHDD involvement. As always, OMHDD staff strives to provide information and assistance consistent with the highest attainable standards of service for clients in a client-centered, client-driven manner.



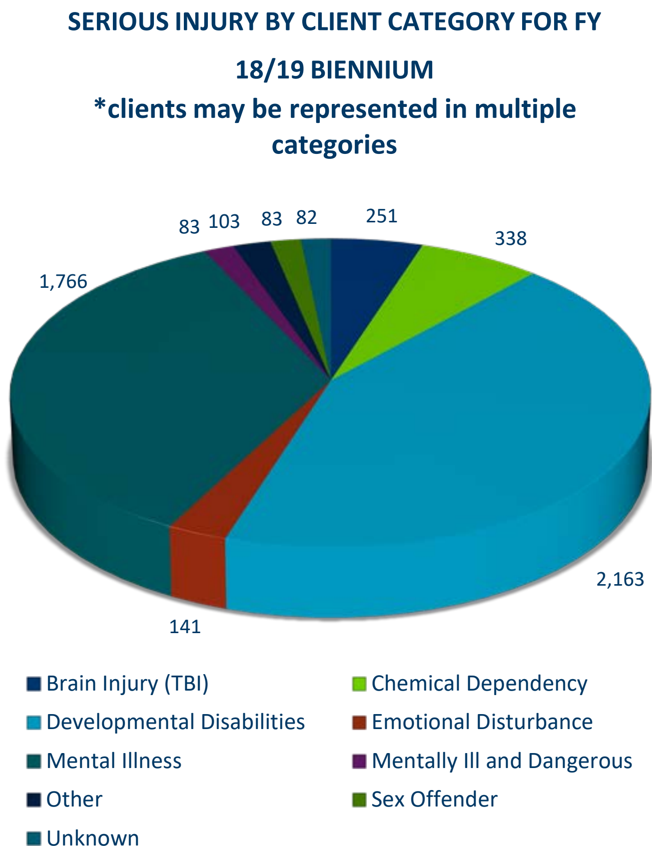


Like all OMHDD cases, Client Services cases occur on a broad continuum of service intensity. Some cases, the Simple Assists, can be resolved relatively quickly with a referral, information sharing that might include a statutory or rule reference, or client self-advocacy strategies and tools that may assist them. These Simple Assists do not reflect that the underlying issue is “simple” by any means, as some can be quite complex, but they are typically completed in a single interaction that can range from a few minutes to an hour or more. Other cases, Client Reviews, are cases that require ongoing OMHDD resources and assistance with Regional Ombudsmen directly involved, involving multiple contacts that may continue for weeks, 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 involved in the case, there is great variety in the types of issues reported to OMHDD and the assistance Regional Ombudsman may provide to clients, their families, guardians, service providers, and other stakeholders. The most common in the FY 18/FY 19 biennium involved client rights, serious injuries, medical issues, social services, and deaths. For serious injury and death issues, these are distinct from the required Serious Injury and Death Reports.

ISSUES REPORTED BY TYPE – FY 18/19			
Issue	**FY 18**	**FY 19**	**Biennium Total**
Client Rights	1,788	1,869	3,657
Serious Injury (Distinct from Serious Injury Report)	1,547	1,931	3478
Medical Issues	1,077	1,153	2,230
Social Services	758	803	1,561
Death (Distinct from Death Report)	707	670	1,377
Dignity and Respect	638	649	1,287
Guardianship/Conservatorship/Rep Payee	547	636	1183
Information	447	664	1,111
Placement	500	531	1,031
Civil Commitment	441	577	1,018
Treatment issues	387	318	705
Abuse/Neglect/Exploitation	346	314	660
Psychotropic Meds	268	278	546
Staff/Professional	265	273	538
Chemical Dependency	295	226	591
Housing	256	212	468
Financial	218	231	449
Other	149	185	334
Legal	154	132	286
Criminal	109	124	233
Insurance	136	94	230
Restrictions	101	124	225
Referral	68	150	218
Child Custody/Protection/Visitation	91	109	200
Data Privacy or Client Records	82	103	185
Public Benefits	87	85	172
Employment	55	59	114
Violations of Rule or Law	54	54	108
Managed Care	28	36	64
Education System	32	27	59
Restraint Seclusion/Rule 40	22	36	58
Personal Care Attendant	22	31	53
Transportation	26	24	50
Legal Representative	12	16	28
Advance Health Care Directive	9	14	23
Training	14	6	20
ECT	8	7	15
Public Policy	2	5	7
Special Project Request	1	2	3
Undetermined	818	1,340	2,158
TOTAL	**12,565**	**14,098**	**26,663**

The Client Services division also reviews the Serious Injuries required to be reported to the OMHDD by agencies and licensed, registered, or certified facilities and programs. This 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 Ombudsman 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 any risk mitigating measures, if any, that may improve client safety and quality of care. We 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 INJURIES REPORTED BY INJURY TYPE FOR FY 18/19 BIENNIUM

***Reports may include more than one injury**

Injury Type	Count
Attempted Suicide	176
Burns (Second or Third Degree)	65
Complication of Medical Treatment	28
Complication of Previous Injury	37
Dental Injuries (Avulsion of Teeth)	56
Dislocation	97
Eye Injuries	36
Fracture	1,697
Frostbite (Second or Third Degree)	27
Head Injury (with Loss of Consciousness)	96
Heat Exhaustion or Sun Stroke	7
Ingestion of Poison or Harmful Substances	224
Internal Injuries	43
Laceration (with Muscle or Tendon or Nerve Damage)	76
Multiple Fractures	240
Near Drowning	4
Other	1,196
Total	**4,105**

The Regional Ombudsmen also 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, and other correspondence submitted to the OMHDD. The client services team also 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 all nursing home closures to monitor the process and help ensure a seamless and appropriate person-centered transition occurs for all displaced residents.

NOTIFICATIONS – FY 18/FY 19			
Notification Type	**FY 18**	**FY 19**	**Total**
Department of Human Services (DHS) Licensing Reports	626	690	1,316
Office of Health Facility Complaints (OHFC) Reports	13	25	38
Department of Education (MDE) Maltreatment Reports	15	12	27
County Child Protection	11	34	45
Nursing Home Closures	20	10	30
Total	**685**	**771**	**1,456**

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, fielding calls from clients and others involved in civil commitment procedures, and providing technical assistance to clients, families, counties, providers, and other professionals.

The CCTRC consists of the Regional Ombudsman Supervisor and two Regional Ombudsman. 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. 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 18/FY 19						
	FY 18		FY 19			
Training Type	**Trainings**	**People Trained**	**Trainings**	**People Trained**	**Total Trainings for Biennium**	**Total People Trained in Biennium**
Commitment Act	15	334	16	394	31	728
Law Enforcement Crisis Intervention (CIT)	18	472	17	430	35	902
Total	**33**	**806**	**33**	**824**	**66**	**1,630**

Medical Review Team

The Medical Review Team began the biennium on July 1, 2017, with two full-time staff members: the Medical Review Coordinator and a full-time nurse reviewer. Data entry and records management were provided by the Office of Ombudsman's St. Paul office staff.

At the end of January 2018, the Medical Review Team welcomed an Office and Administrative Specialist (OAS) for data entry and records management.

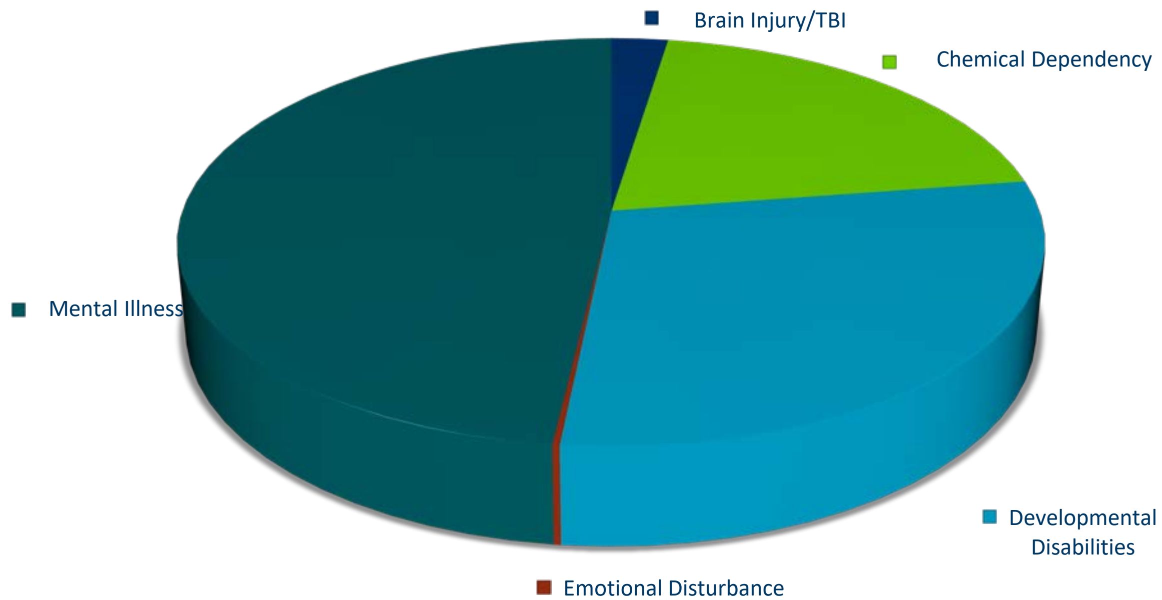
The Medical Review Team serves as a support to the Medical Review Subcommittee, which includes volunteer members of the Ombudsman's Advisory Committee and is empowered under Minn. Stat. 245.97, Sub. 5.

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

Death Reports

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

There were 1088 deaths reported to the Medical Review Coordinator in FY 2018 and 1180 deaths reported to the Medical Review Coordinator in FY 2019 for a total of 2,268 death reports during this biennium. During the 2018/2019 biennium, 55% of the death reports were for clients with mental illness, 33% of the reports were for clients with developmental disabilities, and 23% of the reports were for clients with chemical dependency, as indicated in the accompanying chart.



During the 2018/2019 biennium, 77% of the deaths reported to the Office of Ombudsman were due to natural causes, with 13% due to accidents, and 7% due to suicide.

CLIENT DEATHS BY MANNER OF DEATH – FY 18/FY 19				
Manner of Death	**FY 18**	**FY 19**	**Biennium Total**	**Percentage**
Accident	135	149	284	13%
Homicide	8	10	18	1%
Natural	863	873	1,736	77%
Suicide	62	107	169	7%
Could Not Be Determined	16	30	46	2%
Death Occurred Out of State	3	1	4	0%
Pending Investigation	1	10	11	0%
Total	**1,088**	**1,180**	**2,268**	**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 for the formulation of recommendations in an attempt to prevent the recurrence of similar deaths.

The Medical Review Subcommittee met six times during FY 2018 and four times during FY 2019 to review the deaths and serious injuries of clients that met its established guidelines. During FY 2018, the Medical Review Subcommittee reviewed and closed 35 death reviews. During FY 2019, the Medical Review Subcommittee reviewed and closed 27 death reviews.

FY 18 MRS MEETINGS	FY 19 MRS MEETINGS
8/11/2017	8/10/2018
10/13/2017	10/12/2018
12/15/2017	2/8/2019
2/9/2018	4/12/2019
4/13/2018	
6/15/2018	

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

- A death attributed to suicide while a client was residing in a facility or within 30 days of discharge.
- An accidental death of a client under the supervision of paid staff, if lack of supervision is suspected.
- A death of a client in a detoxification unit.
- A death of a client who has been prescribed four or more psychotropic medications, including anticonvulsants.
- A death of a client with a diagnosis or probable diagnosis of Neuroleptic Malignant Syndrome.
- The death of a client taking clozapine.
- A death of a client receiving services that may be related to a delay or failure to diagnose and/or treat in a timely manner.
- A death of a client that may be related to abuse/neglect.
- A sentinel case. A death report that meets none of the guidelines for full review, but full review is appropriate: i.e., review requested by family members or other sources, when a serious injury precedes a death and raises concerns about quality of care, concerns raised by the MRS on previously reviewed cases, Ombudsman staff or others, etc.

While seeking opportunities to improve the care delivery system, the Medical Review Subcommittee looks not only at individual cases but also for patterns and trends. When it identifies patterns or trends, the Medical Review Subcommittee uses that opportunity to make recommendations focused on the care delivery system. These recommendations may come in the form of a letter to a provider or

agency, a Medical Update, an Alert, a recommendation for a systemic review by the Ombudsman, or the development of educational tools such as our brochure entitled *Information for Individuals and Families about Suicide Prevention*.

The following Medical Alert was created during this biennium:

> Medical Alert: "Pseudoseizures" and "Nosebleed" Leading to a Delay of Treatment and the Death of a Client, November 2017

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

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

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

Ombudsman's Website

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

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

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

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

"Giving Voice to Those Seldom Heard"

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

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