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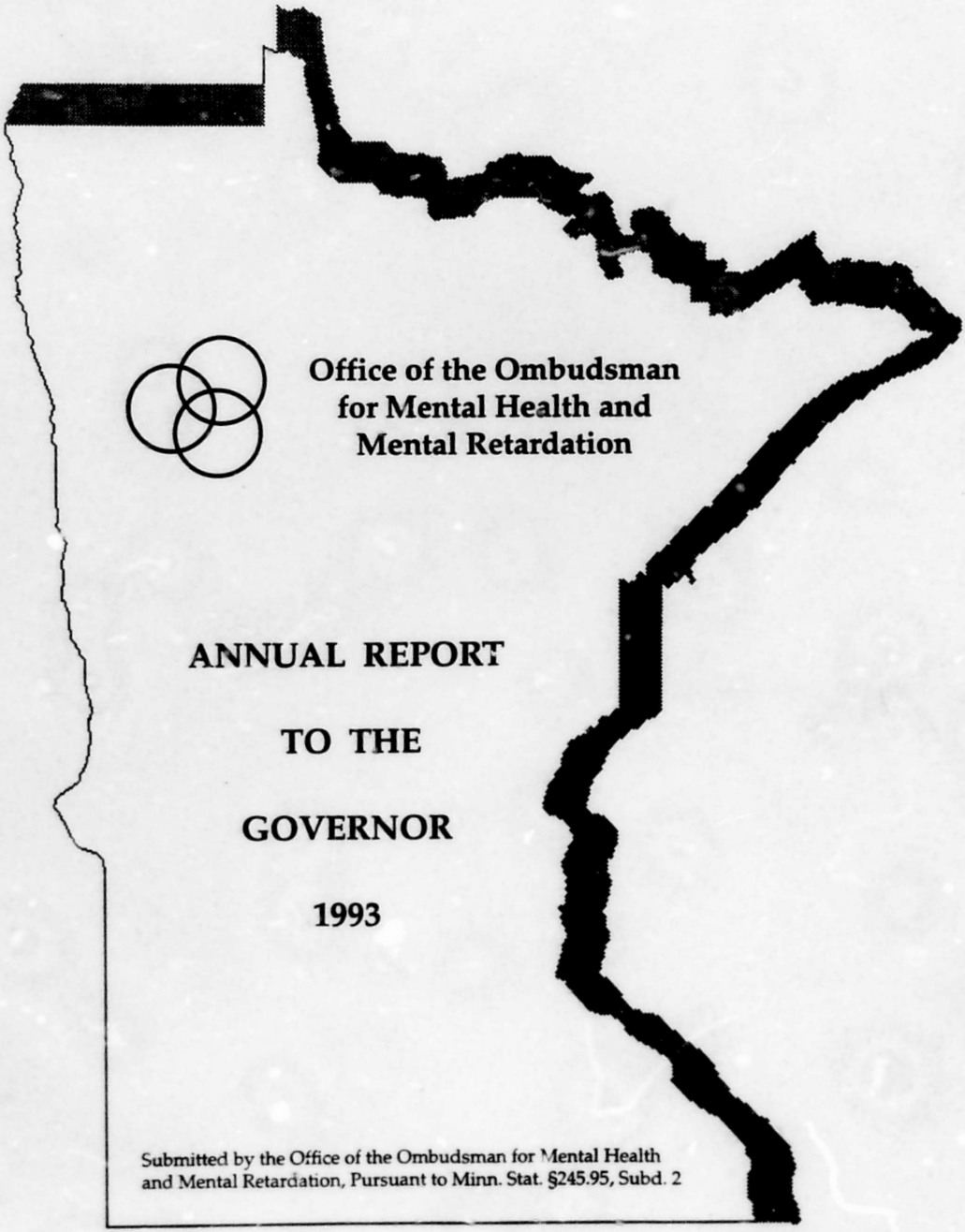

Office of the Ombudsman
for Mental Health and
Mental Retardation

ANNUAL REPORT

TO THE

GOVERNOR

1993

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

STATE OF MINNESOTA
OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION
Suite 202, Metro Square Building, St. Paul, MN 55101
612-296-3848 or Toll Free 1-800-657-3506

December 30, 1993

Dear Governor Carlson:

The accompanying report summarizes the activities of the Office of the Ombudsman for Mental Health, Mental Retardation, Chemical Dependency, and Emotionally Disturbed Children from January 1993 to December 1993.

We have endeavored to present this information in a manner that would enhance your understanding of the office operations, the compilation of data on issues and complaints, and plans for the future. It is important in understanding this report, to note that while the base of the report covers a period from January thru December 1993, our data collection system is set up to compile data by fiscal years. Therefore, the data charts and graphs refer to a period from July 1, 1992 through June 30, 1993. In addition, we have included the relevant state statutes.

This information is integral to sound decision making as it relates to the lives of persons with disabilities. We hope it proves beneficial as you continue to administer public policy for those individuals our Office serves.

Respectfully,

Roberta Opheim
Ombudsman

This information will be made available in alternative format.
For example, large print, Braille, cassette tape, upon request.

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Office of the Ombudsman
for Mental Health and Mental Retardation
Suite 202, Metro Square Building
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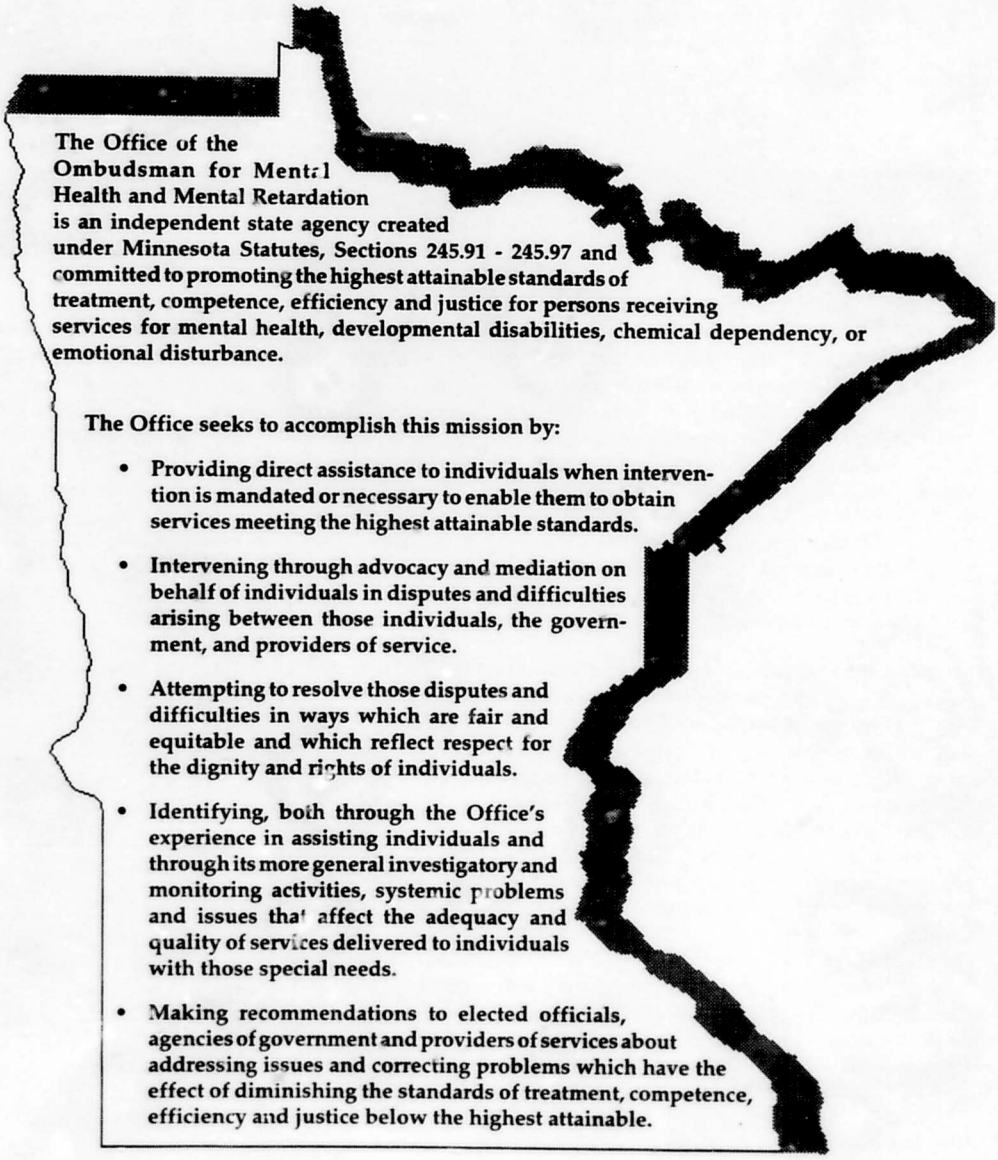
Ombudsman Office Mission Statement



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.**

Preface

OMBUDSMAN: An official intermediary between citizen and government to counteract the delay, injustice, and impersonality of bureaucracy.

Safire's Political Dictionary, 1978

As the newly appointed Ombudsman for Mental Health and Mental Retardation, in April of 1993, I felt the honor and the privilege of being asked to serve the citizens of Minnesota by heading an agency charged with promoting the highest attainable standards of treatment, competence, efficiency and justice for Minnesota's citizens with mental illness, mental retardation, chemical dependency and children with emotional disturbance. I have spent a great deal of time researching, reflecting and discussing with others the role of an ombudsman. The definition given above has helped to put that reflection into perspective and comes the closest to my personal view of the role of an Ombudsman. I have described the role of this Office as being "a conduit for those outside of government to gain access to and fair treatment from the systems inside of government".

Safire's Political Dictionary goes on further to explain the history and development of the ombudsman concept stemming from old Swedish word umbud, meaning proxy, or power to act for another. The crucial point is the right to look into "unreasonable, unfair, oppressive, or unnecessarily discriminatory acts.....even though (executed) in accordance with the law". This has become necessary because of the increasing complexity of government and the public and private systems it regulates. This is especially important to the citizens served by this Office because of their difficulty in accessing or working through these systems due to disability or the stigmas that surround these disabilities. It becomes even more critical when individuals have been deprived of their freedoms through the commitment process.

1993 has been a year of change for the Office of Ombudsman. Over the past year, the Office has experienced three different agency heads, undergone a significant reorganization and re-examination of roles and duties, and adjusted to a biennium budget cut of 12%. Despite the turmoil that this type of change can bring to the service level and stability of any agency, without exception, the staff of this office has worked thoughtfully, energetically and cooperatively to weather these changes, participate in creative problem solving, and emerge a leaner but stronger agency moving forward as a team.

Included in this report, is an organizational chart of the agency that reflects a reorganization of the staff. The Office is now organized by service mandates or service product lines. Minnesota Statue § 245.91-245.97 outlines three specific service areas that should be provided for including advocacy and mediation, death and serious injury reviews, and promoting the highest standards of treatment. It mandates a client advocate at each of the state's Regional Treatment Centers (RTC's).

Roberta Opheim, Ombudsman

The largest function, and the foundation of the Office is the Advocacy and Mediation Services which are performed by the client advocates. Per statue at least one advocate is mandated to be maintained in each RTC. In addition to serving the clients in the RTC's, each advocate has duties in community based services provided in the various regions around the state. Included in this report is a map of Minnesota that shows the various regions and the advocates that are assigned to serve them. Besides the advocates in the RTCs, we have two advocates that serve the metropolitan area due to the large numbers of our populations that reside in this area. One serves the east metro area and the other the west metro area. In addition, we have one part-time intake worker. In the future, there will be a need to expand the intake function to full time to provide continuity and for an effective system of sorting contacts and making sure they get to the correct region in an expedited manner. This would allow the regional advocates to be more efficient.

The Death and Serious Injury Review service is coordinated by one staff member who has a nursing background and works closely with a volunteer Medical Review Subcommittee. This committee, based on established criteria, reviews death and some serious injuries to look for recommendations that could be made to improve services to clients and minimize any potential for unnecessary deaths or injuries. Client Advocates assist in this process by conducting reviews, within their regions, of the circumstances involved in a given report. In addition, the overall data is maintained in a computer data base to be trended and monitored for unusual or concerning trends that could lead to systemic review or possible recommendations for service improvement.

The last service area is the System Review and Legal Policy. While the legislation has always mandated the promotion of the highest standards, this broad category was handled in a number of different ways in the past. During 1993, this agency conducted a survey and invited focus groups to discuss the services of this office. One of the strongest messages that came from that process was the need to be looking into broader system issues. That instead of solving the same problems over and over again, some efforts had to be devoted to changing the systems so that the same problems would not continue to arise. A lot of time was spent during 1993 analyzing what that meant in terms of the services of this Office. The Office had always actively participated in the legislative process as it affected our service groups by either promoting or opposing legislation that was thought to be beneficial or not beneficial to our clients. In addition, it had occasionally conducted investigations of some facilities or programs. It was decided that function had to be more specifically defined and an organized process established. There was some debate as to whether this office should diminish the efforts in the area of individual advocacy and mediation in order to move into the area of systemic review.

During 1993, the staff participated in a retreat facilitated by The Department of Administration's Management Analysis Division. The focus of that retreat was to define and refine the System Review Process. It became clear that the choice could not be either individual advocacy or system review but a process where one is built on the other. Clearly the individual advocacy services are sometimes a lifeline or an avenue of last resort for some of the individuals that we serve. While some of the issues brought forward may not seem important in the large scope of mental health and developmental disabilities arenas, they may be the most important issue in that citizen's life at that time. If we could not provide those basic services then what were we here for? But if we could not improve the system, we would be doomed to constantly be solving the same problems over and over again. In addition, it became clear that the individual advocacy was the basis for our view into the system and for the foundation of which issues could or should be addressed. Out of the retreat came a system review division of the office with an established policy and a coordinator. The coordinator works with the entire staff to determine which systemic issues can and should be addressed. When a system issue is identified, a multi-disciplinary team is assembled to plan and execute the review. The coordinator would then also be responsible for forwarding any suggestions for improvement to the appropriate person, agency or legislative body.

The Office is then rounded out by a small administrative support staff that makes sure all of the

necessary administrative functions are executed so that the direct service staff can efficiently provide the mandated services.

In 1993, all levels of state government were asked to reduce their base budgets by at least five percent (5%) and in the case of this agency the amount was even more. As a result, drastic measures had to be taken to try to provide for the mandated services with a reduced budget. There were a number of areas where frankly, the agency could and should be more cost effective and those measure were taken to reduce cost and improve accountability. In addition, a number of areas where costs are legitimate and necessary to the effective operation, these areas were eliminated, postponed, or provided for in another manner. Included in the cost cutting measures were:

- Reduction in staff - one full-time position was eliminated, five full time staff agreed to some voluntary leave without pay, and two positions were involuntarily reduced.

- Reduction in space - a new lease was negotiated to reduce the amount of space that was rented by the agency. Space given up included the space for the eliminated staff position, and conference space. Conference space is now sought on an as needed basis either from other agencies or in other public buildings.

- Training - while this is a necessary item, this line item was eliminated temporarily and all sources of free training was sought. When necessary, one staff member is sent to training and then trains the balance of the staff.

- Operational Budget - all line items were scrutinized and reduced or eliminated as appropriate. All equipment and supplies that could be, were postponed or eliminated.

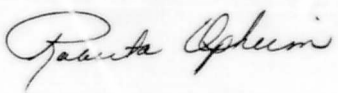
- Reduction in travel and number of meetings - efforts were made to improve electronic communication and to reduce the necessity for staff to travel from all parts of the state for meetings.

Some of these changes can and should be permanent, but some of them are simply postponed, and if not addressed in future biennium's, will significantly hinder the agency's ability to provide the requested/required services.

As you review the enclosed information, you will notice that the format has changed slightly from previous reports. It is important to note that while the general information reflects the calendar year 1993, the data is collected and reported by Fiscal Year and so represents a period from July 1, 1992 through June 30, 1993. In addition, there is not as many direct comparisons from year to year as has been done in the past. This was done for a number of reasons. During 1993, there was an in-depth review of the data collection system. A number of changes were proposed, designed, tested and revised. As a result, some of the items and categories changed, making direct comparisons difficult. Also as a result of the review, some problems were discovered with the computer data base system and with how and what data was reported, as well as the manner in which it was reported by agency staff. There were some discrepancies between regions. This presented some dilemmas and delays in the preparation of this report. This report reflects the best efforts of this agency to provide you with accurate information. We feel confident that the information provided, accurately reflects the distribution of the issues and requests for services by type of population and type of issues or requests for service. Starting in FY 1994, data should be more uniformly collected allowing for better comparisons, for monitoring the system, as well as providing for effective administrative monitoring and resource allocation.

I hope this overview provides you with a better understanding of the following report. I look forward to working with the Governor, the Legislature and other state agencies in providing the leadership and stability for this agency and the citizens it serves as we move into 1994 and beyond.

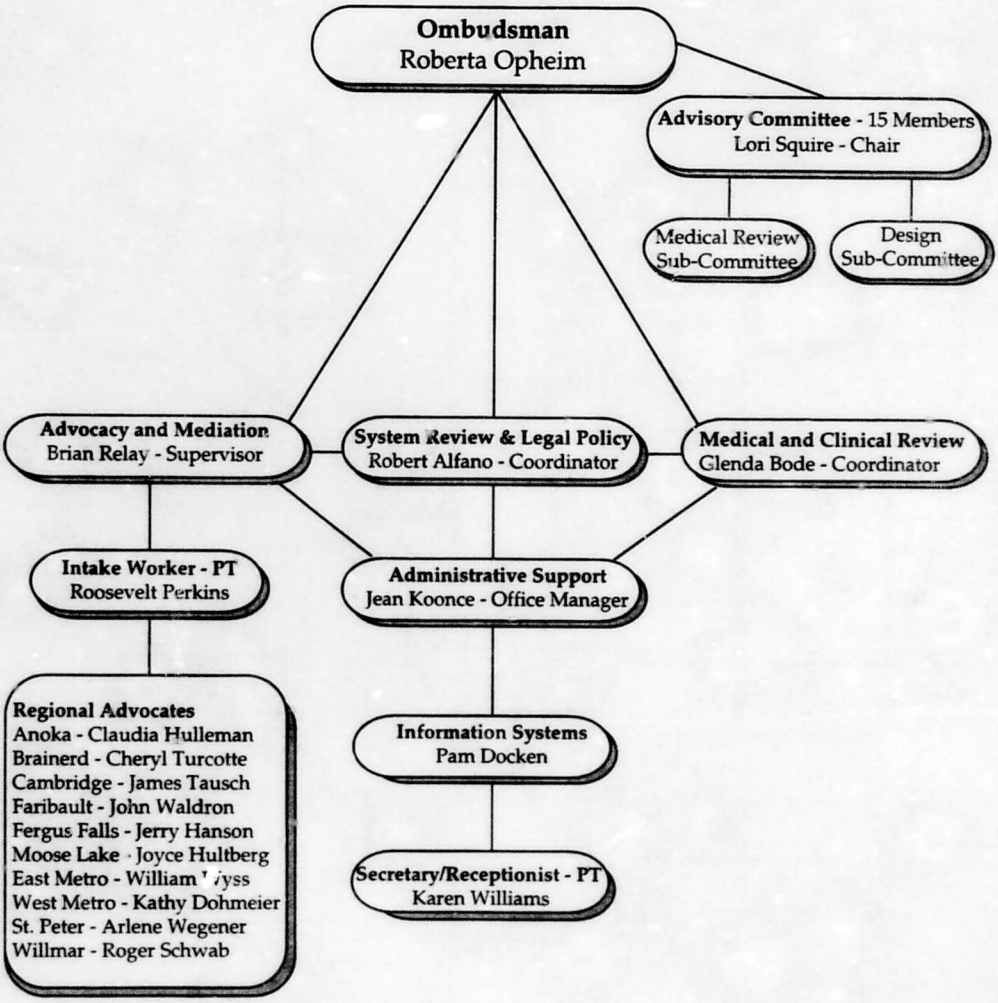
Respectfully Submitted,

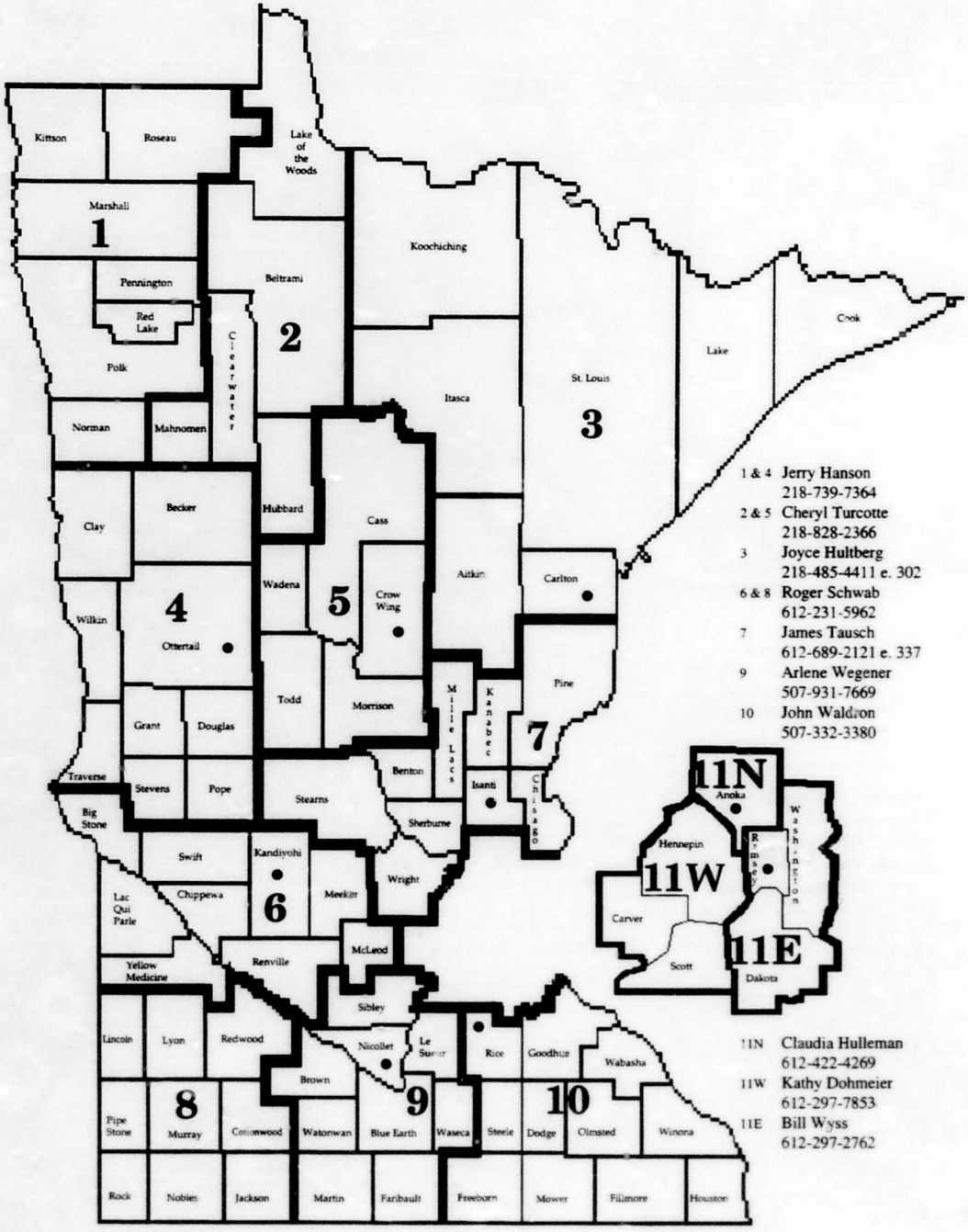


Roberta Opheim
Ombudsman

Ombudsman Organizational Chart

as of December 30, 1993





1 & 4 Jerry Hanson
218-739-7364

2 & 5 Cheryl Turcotte
218-828-2366

3 Joyce Hultberg
218-485-4411 e. 302

6 & 8 Roger Schwab
612-231-5962

7 James Tausch
612-689-2121 e. 337

9 Arlene Wegener
507-931-7669

10 John Waldron
507-332-3380

11N Claudia Hulleman
612-422-4269

11W Kathy Dohmeier
612-297-7853

11E Bill Wyss
612-297-2762

Advocacy and Mediation

The function of advocacy and mediation has always been and will remain an intregal part of the Office of Ombudsman's overall mission. Client Advocates provide services to a variety of Minnesota's citizens. Although our primary clients are residing in licensed facilities, programs or services, other clients who are living independently are also calling for assistance. These clients are typically disenfranchised citizens, without a strong voice, and experience the destructive stigma that society places on mental disabilities including; discrimination, violence, and exclusion. Advocates find themselves increasingly being asked to provide general and technical information on a wide range of subjects. Advocates are also called on to do presentations and provide in-service training on relevant protection and rights issues. Advocates provide extensive consultative services to other professionals, service providers and policy makers. All of these activities combine to bring issues, effecting the lives of mentally disabled persons in Minnesota, into focus.

This past year, the client advocates have placed additional effort into an introspective process intended to assist in identification of our primary mission, and into developing a long term strategy to focus more attention on larger systemic issues. Individual case advocacy is still very important. However, we strive to develop self advocacy skills in clients to promote self worth and skills to last a life time. As we focus on the systemic issues that effect large numbers of mentally disabled persons, we gain more effective use of public dollars and potentially resolve issues that effect large numbers of Minnesota citizens.

The following variety of cases will provide examples of the work our client advocates are called upon to engage:

Helping Citizens Gain Needed Services

A county case manager contacted the regional client advocate, at the request of the client's family. Apparently, the parents and their adult developmentally disabled daughter had recently moved to Minnesota. They had applied for day habitation services for their daughter and the provider had declined services because of transportation costs. The family lived off the regular bus route in a rural county and the funds were not available to transport her to the Day Activity Center (DAC). Since the county had also declined to pay the additional costs, and the elderly parents were unable to provide transportation, the parents filed an appeal and the client advocate was contacted. After meeting with the family, obtaining pertinent documents from the county and the DAC, along with researching pertinent state statutes and rules, the client advocate presented the case to the appeals referee. The outcome of the situation was that the DAC was instructed to provide transportation and the costs were covered by a rate variance increase.

Helping Legislators Provide Constituent Services

A state legislator contacted the Ombudsman's Office because of a concern from a constituent. The family had a developmentally disabled son in an RTC and there were issues being raised because of his social security checks. The parents were payee on the checks and had been receiving them on a regular basis. The procedure they were to follow was to withhold the designated personal needs allotment and submit the balance to the State of Minnesota towards their son's cost of care. However, the parents had been withholding various amounts of additional money for other items their son needed/wanted. It was their understanding that this was permissible if the money was spent for his care. At the current time the family owed several thousand dollars in back payments and they were being contacted regularly by collections personnel. After speaking with the family and all other involved individuals/agencies, the client advocate arranged a meeting of pertinent individuals. "The outcome of the meeting was that the family would pay the additional

funds withheld during the current year (three months) and would only withhold the appropriate personal needs. In exchange, the current money owed would be conditionally forgiven (as long as they abided by their agreement) and the collections personal would stop contacting them. The parents would also be able to remain as payee for their son, which was very important to them.

Mediation Services

A nurse on an inpatient mental health unit contacted the client advocate regarding a client who was being evicted from their apartment building. The individual was several months behind on rent payments and also owed money on utilities. The landlord had now served an eviction notice. The advocate met with the individual to verify their desire to keep the apartment and their financial standing. The advocate also met with staff to clarify when the individual could leave treatment. The advocate had several contacts with the landlord and negotiated a payment schedule which was financially feasible. The rent payments were to be kept current and the back rent was to be repaid in a timely manner. This plan was accomplished through connecting the individual with appropriate assistance programs including rent and fuel assistance, along with food stamps. This allowed the individual to keep the apartment.

Helping Case Management Services

A vocational case manager at a DAC contacted the client advocate regarding a procedural change at the DAC. The clients were now to begin receiving their monthly pay checks at their community work sites, rather than at the DAC. One of the residential providers had expressed concerns over several of their clients, and with one individual in particular. The advocate met with DAC staff, residential provider staff, the client and her mother. They then provided all parties concerned with a written document of findings and suggestions on how the procedural change could more effectively be integrated into the programming plan.

Helping Case Management Services

A county case manager contacted the client advocate to request assistance in a proposed discharge plan for a developmentally disabled client. The individual had resided in the same community facility for 10 years and had attended the same DAC during that time. There were behavioral difficulties which were relatively stable at the current time. Increasing family contact had developed recently and the family was requesting relocation of the individual closer to the family. Several team members objected to the move because of the past behavioral issues and the loss of significant relationships for the person, if they moved. The case manager was asking for an assessment by the advocate and an opinion as to what might be the best approach, if the move were to take place. After reviewing pertinent records, meeting the involved individuals and visiting the involved providers/facilities, the advocate provided the case manager with a report of findings, concerns and suggestions. The proposed move did take place.

Mediating for Quality Services

A county case manager requested consultation and advice regarding the overall status of an adult DD client and how the case manager and guardian could best work together to incorporate the client's needs and goals into the Individual Service Plan and facilitate positive changes for the client. The client advocate assigned met with the client. Records were reviewed and there were detailed discussions with the guardian, the case manager, and service providers who work closely with the client and know him/her well. After the record review and interviews, findings, observations, and suggestions were shared with the case manager and guardian. Although difficulties and challenges arose, these were dealt with. Changes were made in the services the client receives which incorporate the client's goals.

Monitoring for Quality Services

A complaint was received regarding environmental and working conditions for clients at a day training and habitation services provider. An unannounced visit was made at the site by a regional client advocate. Portions of the complaint were substantiated and additional concerns were identified during this visit. The appropriate licensing agency was consulted. Findings, observations,

and specific suggestions were shared with both the service provider and the licensing agency. The service provider did subsequently make changes to improve the environmental and working conditions for the clients. A follow-up report was made to the original source.

Providing Recommendations for Change

A regional client advocate was consulted by facility staff and requested to provide input on proposed changes in the facility's admission policy and procedures. The advocate consulted with peers and surveyed practices at similar facilities around the state. Concerns regarding certain aspects of the proposed changes, and suggestions regarding these concerns, were shared with facility staff. These were carefully considered and modifications in the proposed changes were made.

Monitoring for Quality Medical Care

The medical review coordinator for the Ombudsman's office and a regional client advocate discussed concerns identified following a client serious injury report made to our agency as mandated in Minn. Stat. § 245.94, Subd. 2a. The client advocate followed up with on site review of records, consultation with key facility staff, and a report to the local adult protection agency. Following these contacts, the focus of the facility's internal review process was clarified and, subsequently, changes were made in practices and procedures related to the circumstances surrounding the client injury.

Protecting Client Rights

A mental health client contacted our agency requesting assistance to contest a discharge notice received. This client was receiving treatment at a residential treatment facility in the community. Staff requested that the client either moved to another location of their program or be discharged. The advocate met with the client who stated a preference to remain in the facility where now residing. Both the client and the advocate met with facility staff to discus the issue of discharge. However, the staff still insisted that the client moved or be discharged. After reviewing the licensing standards, it was discovered that the particular location where the client resided had no DHS license. Because of this discovery, The advocate was able to apply the landlords and tenants statute to this case which resulted in the client not being discharged or moved.

Helping Clients Access Services

A mental health client contacted the Office to request assistance in obtaining services for which the client was denied. The client was denied services to a program that assists clients to build stronger relationships. With the clients consent, I contacted the appropriate staff to pursue the clients request to enter the program which resulted in a meeting with all parties. As a result of this meeting were that the client was able to participate in the program that could meet the clients expressed needs.

Helping Clients Access Treatment

An intake was received by telephone from a mental health client who was living independently in an apartment, and requesting to be hospitalized. She was scheduled to see her doctor that afternoon but could not leave her apartment. I phoned her doctor and social worker who made arrangements for her to be hospitalized and also have someone attend to her apartment. The client was hospitalized as requested for mental health treatment.

Client Advocate working with a Client

Contacts by Issues

The graph and table on the following page demonstrate the variety on contacts our staff are actively engaged in. These contacts comprise the issues brought to the attention of the Ombudsman Office, between July 1, 1992 and June 30, 1993.

Each of these areas can offer various insights into overall quality of care for persons with mental disabilities. This past year, some fluctuation in numbers were observed and had been expected. During FY 93, the Office of Ombudsman had three momentous changes that we believe will move our office closer to fully realizing our legislative mandate. We did an introspective review of our role and function as it relates to promoting the highest quality of services for mentally disabled persons in Minnesota. We completely revamped our computer systems to provide a more comprehensive reporting of contacts and issues. We made a significant transition from an, exclusively, individual client advocacy/mediation approach, to a combined individual client centered approach and a systemic client or issue approach.

The Graph One provides an overall visual presentation, while Table One provides actual numbers and percentages. The data areas listed as Consultation, Placement, Treatment and Serious Injuries are significant. The area of consultations has significantly grown as we become more proactive in our approach to potential issues, and more citizens and service professionals find our services credible, and providing them with quality information. Placement and treatment are significant areas that tend to go together. As our outreach with community facilities and programs continues to grow, and resources to meet a clients basic needs decreases we can project this area to grow. Serious injuries are a significant source of contacts with our office and provide our staff with information needed to monitor the overall function of facilities and programs in their region. (See Medical Review Clinical Review Function for detail.)

Graph One

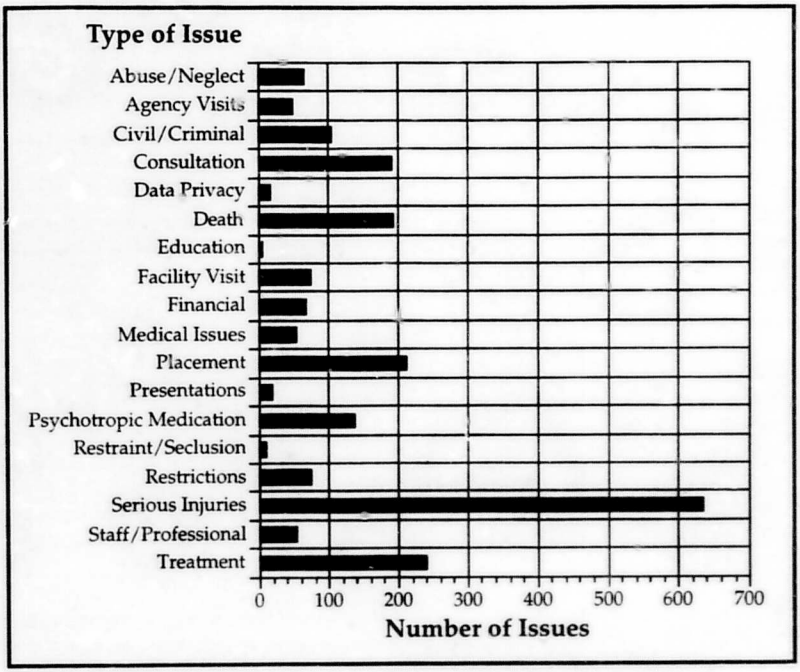


Table One

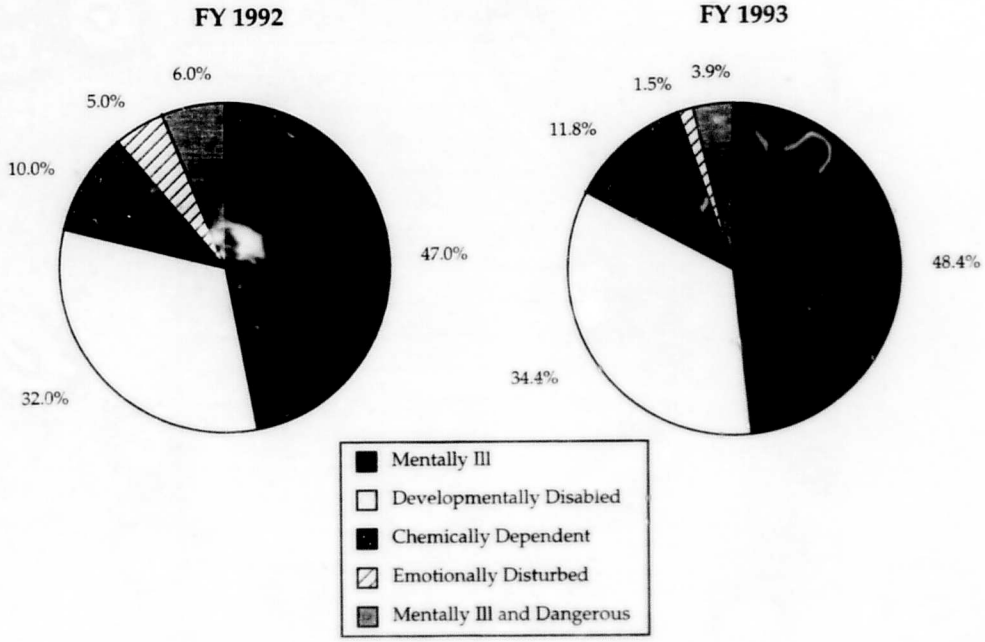
Type of Issue	Total # of Contacts	% of Contacts
Psychotropic Medication	137	6.14%
Placement	212	9.49%
Restrictions	75	3.36%
Financial	68	3.05%
Medical Issues	53	2.37%
Serious Injuries	634	28.39%
Civil/Criminal	104	4.66%
Staff/Professional	54	2.42%
Treatment	240	10.75%
Data Privacy	15	0.67%
Education	5	0.22%
Restraint/Seclusion	9	0.40%
Abuse/Neglect	64	2.87%
Death	193	8.64%
Facility Visit	95	4.25%
Consultation	191	8.55%
Presentation	24	1.07%
Agency Visits	60	2.69%
TOTAL	**2233**	**100.00%**

Contacts by Disability

These graphs demonstrate a fairly consistent pattern in regard to the individual disability groups receiving services from the Office of the Ombudsman. Individuals receiving services for mental illness continue to be our primary service recipients. One reason may be the lack of a comprehensive continuum of mental health services. Another reason may be our states continued reliance on Regional Treatment Centers as the primary service provider.

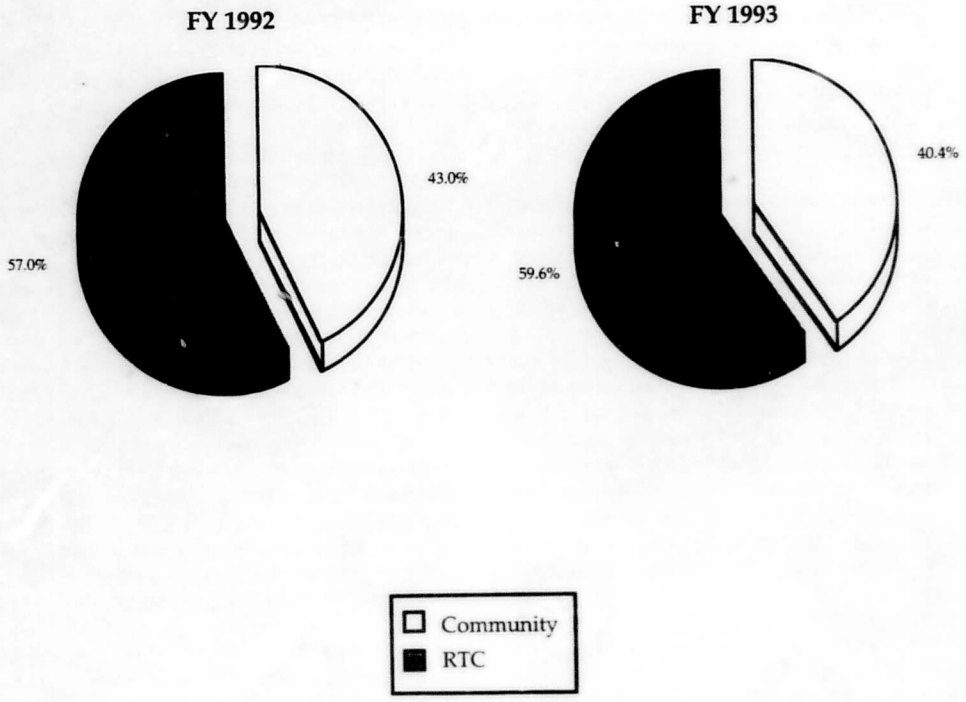
It is a safe assumption that individuals with developmental disabilities will continue to demand a large portion of our services. These individuals are many of the most vulnerable persons in our society, and continual quality management is essential. As the state downsizes large facilities in favor of smaller Community based options, we expect to see greater numbers of community contacts in a diverse group of options from small Intermediate Care Facilities for the Mentally Retarded (ICF/MR) facilities to foster homes and semi-independent living apartments. These will continue to provide us with an outreach challenge as we promote the highest attainable standards in the community as well as in regional treatment centers.

The numbers of chemically dependent person contacting our Office increased slightly during FY 93. This may be related to the involvement the Office of Ombudsman has with the Hennepin County Detox crisis and our commitment to further outreach to monitor detox services in Minnesota.



Contacts by Regional Treatment Center or Community

During FY 1993, a 2.6% drop in community activity was noted, as demonstrated by the comparison graphs below. This temporary drop was anticipated due to our introspective review of role and function. During our review we heard from consumers, who told us that many people were still unaware of our services. We are faced with the challenge of getting the word out, during a period of downsizing and development of community options, while budgetary restrains keeps us from offering the services envisioned by our legislative mandate. Our goal is to meet our challenge by providing balance to our services, seek to resolve systemic issues that will assist many clients in a labor and cost effective manner, and continue to provide coverage to a growing community provider system.



System Review and Legal Policy

Along with direct advocacy, systemic review of mental disability issues helps the Ombudsman Office promote the highest attainable standards of care and treatment. During the past year, the Office more fully developed its systemic review function, and designated a staff member as a system review coordinator. All staff were engaged to develop priorities and procedures for determining systemic issues. The purpose of Ombudsman systemic review is to identify and address issues of high volume, high risk, and/or high impact that affects clients well being or their quality of life on a system wide basis. Generally, a review investigation will be considered when an agency, facility or program is providing inadequate or poor quality services to clients. By conducting a system review, the Ombudsman seeks to improve standards of care and treatment in agencies, facilities and programs by making recommendations, and when appropriate, making public the findings and recommendations of the report.

Ombudsman system review consists of four phases: monitoring, assessment, corrective action, and follow-up. If it is assessed that an issue meets criteria for system review (high impact, volume and risk, and adverse affect on clients well being) an action plan will be developed and a work team convened. A work plan may consist of gathering additional data on an identified issue, on-site visits, meetings with management/staff of an affected agency, facility or program, or drafting a report summarizing findings and making recommendations to correct identified problems. In some cases, the Office may issue a report to the public (however all completed reports are public data). A follow-up phase then tracks response to the Ombudsman's recommendations.

1993-94 System Reviews

After implementing a system review policy in August 1993, the Ombudsman Office identified several issues as systemic in nature. These issues included:

1. The Peoples Community Care Residence (PCCR)

This St. Paul home for the developmentally disabled (DD) first came to the attention of the Ombudsman Office when parents complained of poor quality care. Shortly thereafter the facility was in the news regarding a death of a client at the facility. Also the Departments of Health and Human Services found serious deficiencies in management, client protection, and health and nursing care services. The state Attorney General's Office opened an investigation on the facility, and issued criminal complaints of neglect against certain management of the facility. In September, the Office opened a system review of the facility to help fill in the gaps being left by other state agencies, as parents felt confused, frustrated and concerned over the events at People's Community Care Residence.

In assessing the situation, it was determined that the best role for the Ombudsman Office to play was in bringing the various parties together to improve communications, and to provide explanations of the process for the families. Also, we did not feel there was a need for our Office to conduct a separate in-depth investigation in light of work of the other agencies. In September, the Office held family meetings with representatives from Ramsey County, Department of Human Services (DHS), and People's Community Care Residence to discuss the receivership process, and timelines for People's Community Care Residence to correct deficiencies. Ombudsman staff also made unannounced visits to the facility. In October, the Office held a second families meeting when the Minnesota Department of Health citations became public information, this time inviting Minnesota Department of Health representatives to explain the process for corrective action. Two days after the meeting the Minnesota Department of Health recommended that the facility be placed into receivership. The Office then put into place a monitoring plan to review changes being made by the new ownership.

2. The Madden Kimball Home

For years reports of abuse, neglect, substandard care, and management unresponsiveness had been generated from this Kimball, Minnesota facility for the developmentally disabled, by county and state officials. Yet little or no corrective action followed. In response to specific reports regarding quality of care made to our agency, our regional advocate began monitoring client care at the facility. This monitoring was lifted to a system review in the fall of 1993, with extensive data collection, interviews, and on-site visits being conducted by Ombudsman staff. In a report published in January 1994, the Ombudsman Office noted serious problems in the facility's resident programming, a bleak physical environment, and overall poor management abilities. The report listed several recommendations for the facility to improve programming and maintain facility according to contemporary standards. Following the report publication, the DHS worked with the facility to place it into receivership, and move clients into better quality care settings. As part of its follow-up, the Office worked on helping with placement, and monitored the transition.

3. Community Integration of the Developmentally Disabled

Following the problems experienced at the Ravenna Ranch group home last year, the Office looked at whether this situation was an isolated case, or whether the Developmentally Disabled have problems being accepted into the community. As part of a system review, the Office surveyed the state's counties to determine if they had experienced placement problems with the Developmentally Disabled not being welcomed into community settings. A large portion of the counties responded that they had indeed experienced this type of a problem. The Office is working to coordinate a conference on this subject to bring together state, local government, legal, and advocacy representatives to discuss solutions to reduce barriers facing the developmentally disabled in the community.

4. Waivered Services

With accelerated downsizing of regional treatment centers, the role played in the system by waivered services becomes larger. In 1994 the Ombudsman Office will focus a systemic review on how to assure quality services in light of less restrictive waiver standards.

Legislative Monitoring

The Office also conducts systemic review through policy oversight and legislative monitoring. The Office was very active in the 1993 session. Some of the issues the Office was involved with were:

- The Ombudsman joined with other advocacy groups to fight passage of a bill which would have increased the mixing of criminal population with vulnerable adult mentally ill individuals via the commitment act;
- Worked on language for wet/dry shelters that was incorporated into the final bill;
- Office worked to amend a bill that would have allowed guardians to decide for patients whether their presence in a treatment facility could be disclosed to callers or visitors who may seek to communicate with the patient. The Office worked to get language in the bill that would mandate guardians to consider the opinions of the patient or resident regarding disclosure of such information.
- Office provided supporting testimony for legislation such as the creating of pilot projects for mentally ill residents in public housing.

Between the 1993 and 1994 sessions, the Office continued this activity by:

- Becoming an active participant on the Vulnerable Adult Task Force being coordinated by the Attorney General's Office, that is seeking to make changes in the vulnerable adult laws;
- Actively supporting the creation of a Supreme Court Task Force to study and revise the commitment act;
- Introduced legislation to extend the Ombudsman Advisory Committee, to allow for citizen participation, by eliminating its expiration date.
- The Office has also been monitoring the numerous health care proposals to insure that adequate benefits are provided for the mentally ill, developmentally disabled, chemically dependent, and emotionally disturbed.

Medical and Clinical Review

The Office of Ombudsman for Mental Health and Mental Retardation is mandated by statute to receive reports of all deaths and serious injuries to persons with mental illness, developmental disability, chemically dependency and children with emotional disturbance. The reports are made to the Medical Review Coordinator who makes the decision to do a more detailed review or to simply trend the information. The Coordinator is responsible to provide medical consultation to the staff of the office when they confront issues that need some medical judgment.

Fiscal Year 1993 was a year of stabilization and catching up, with some reorganization and redefining of roles. The Medical Review portion of the Office has consulted with System Review and Advocacy and Mediation in a collaborative way. This cooperative effort strengthens and enhances the quality of the work of the Office as a whole.

The Office of the Ombudsman for Mental Health and Mental Retardation uses information from many different sources in order to address quality of care issues. The mandated reporting of serious injuries has proven to be a valuable source in providing information about the quality of services received by mentally ill, developmentally disabled, chemically dependent, and emotionally disturbed individuals. These reports are reviewed on an individual basis. Client Advocates are notified and may conduct follow-up in cases where quality of care questions are involved. In addition, information from serious injury reports is compiled and aggregated. This aggregation allows trends in injury patterns to be recognized and are used to inform providers of safety concerns and identify areas needing focused reviews by the Ombudsman Office.

The Medical Review Subcommittee (MRS), which is part of the Advisory Committee, who, with the coordination of the Medical Review Coordinator and the hard work of other Ombudsman staff, have successfully taken the back log of deaths waiting for review and brought the list up-to-date. The committee reviewed eighty seven cases at nine meetings. Many of those cases had accumulated during the time that there was no Medical Review Coordinator on staff. At the end of the fiscal year, there were only four cases pending review because additional information was requested by the MRS. There was a total of 193 deaths reported to the Office of the Ombudsman in FY 93. Of that total, 134 or 70% were closed at the time of intake because they did not meet the guidelines for review.

Several issues have been raised through the review of the deaths. Logs have been kept on these issues so that we can gather more information and later put those concerns into the Medical Update. There was an example of this in one of our newsletters when we alerted providers to be sure the emergency equipment was in working order and that the staff were aware of how to use it. The format has been changed and the update will be sent out to the appropriate places as a separate mailing. A copy of the first update is on page 17 and 18. The Medical Update will be a regular publication that will be shared with providers when the MRS identifies an issue. The goal is to alert providers to potentially harmful situations and provide enough information to avoid unnecessary harm to an individual or a group of clients.

The use of the drug Clozaril is one of these issues. Clozaril is a drug that is new and specifically for the treatment of schizophrenia. We added to the criteria so that every death of a person who is taking clozaril automatically has a full review. There has not been any indication that clozaril caused any of the deaths that have been reviewed. The full review of all deaths of clients who are taking clozaril will continue for now.

There is a plan to expand the role of the MRS to be available as technical consultants on individual cases.

DETOX

Update 94-001

The Medical Update is based on the work of our Medical Review Subcommittee and should be posted prominently We will make an effort to take an active role in improving the services provided to people with disabilities by letting you know when we find an important issue while we review the deaths and serious injuries. We want to thank you for your prompt reporting of deaths and serious injuries. You are helping us meet our mission.

MEDICAL UPDATE

MEDICAL UPDATE

MEDICAL UPDATE

MEDICAL UPDATE

March 1, 1994

This Medical Update is based on the review of two deaths of clients who both died in Detox Centers. The individual case summaries are on the reverse side of this notice.

There were some differences in these cases:

1. One was male, age 43: the other a female, age 34.
2. One was a major recidivist, the other was a first time admission.
3. The deaths occurred at different Detox Centers.

There were similarities:

1. The blood pressure and temperature was not taken.
2. There were scheduled checks that were missed.
3. There were no requests for medical consultation.
4. Both had ingested other substances with Ethanol.
5. Both died within three hours of admission.
6. Both had poisoning listed as cause of death.

The Medical Review Subcommittee recommends that you review your procedures for content and comphension and include the following:

1. Do checks when scheduled and as needed.
2. Review with all staff the importance of complete vital signs and techniques for obtaining vital signs from an intoxicated person.
3. Add a section to the admission assessment that alerts staff to at least the following:
   a. trama
   b. head injury
   c. Antabuse use
   d. Isopropanol odor or evidence of ingestion
   e. prolonged vomiting
4. Consult with M.D. about when to call and transfer the person to acute care.

P L E A S E P O S T

STATE OF MINNESOTA

OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION
Suite 202, Metro Square Bldg., St. Paul, MN 55101
(612) 296-7831 or 1-800-657-3506

CASE SUMMARIES

CASE #1

This person was picked up by the State Patrol and transported to a detox unit because of intoxication. Staff were told that he/she was taking antabuse. There was a strong odor of ETOH (alcohol). There was severe intoxication and vomiting. There were a number of other medications in the person's possession in addition to the Antabuse. One hour after admission the person was unable to be aroused, the respirations were 18 and the pulse was 76. A blood pressure was not taken during the stay at the facility. There were two hours and forty five minutes between the time the person was admitted and the time of death.

There was no documentation that routine monitoring had been done.

The death certificate states the cause of death was Acetaldehyde poisoning and alcohol-disulfuram (the generic name for Antabuse) ingestion. The manner of death was accidental. The poisoning occurred from ingesting a large amount of alcohol while taking Antabuse.

CASE #2

This person was taken to Detox by Police after being found "down" on the street and extremely drunk, profane and combative. On admission he/she was alert, uncooperative, slurred speech, ataxic, breathing normal, skin color normal. Staff were unable to do vital signs. There was an odor of both ETOH and rubbing alcohol. He/she was put into seclusion ten minutes after admission. The individual was resistive and needed assistance to ambulate.

There had been over one hundred prior admissions of this individual to the Detox.

Fifteen minute checks were done for the first hour. The next check was thirty minutes after the last fifteen minute check and the patient was in distress. CPR was started and 911 was called and he/she was transported to the medical center. He/she was pronounced dead one hour later.

The death certificate lists the cause of death as acute alcohol toxicity. The manner of death was accidental. The underlying cause was acute ethanol and isopropanol poisoning.

Medical Review Sample Cases

Death During Holding Procedure

The MRS reviewed a death of an individual with Downs Syndrome and severe self-injurious behaviors (SIB). The client had an approved Rule 40 program for holding in the prone position for a specified period of time in order to prevent SIB. The client became unconscious shortly after the hold was released and later died without regaining consciousness. Copies of published articles that warn against holding a person with Downs Syndrome in the prone position and a reminder was sent to the Regional Review Committee.

Improving Quality of Care

In some cases, the MRS has recommended reporting situations that are potentially or actually out of compliance with the established standards to a regulatory agency such as Office of Health Facility Complaints, the local Vulnerable Adult investigator or DHS licensing. There have also been recommendations to have the local client advocate follow-up on citations and orders that are issued from these agencies to assure that the proper changes are made. The MRS and the staff of the Ombudsman Office is able to go beyond the usual standards and work with professionals and service providers to improve the delivery of services and make recommendations that will help the client attain an even higher level quality of life.

Medical Review Subcommittee

Death Following Therapeutic Intervention and Containment

A client had a seizure during a manual restraint, went into cardiac arrest and died. The client did not have a history of a seizure disorder. After that review the MRS made a recommendation to the Department of Human Services to always have a special review by the Therapeutic Intervention and Containment expert at each Regional Treatment Center (RTC) after restraint leads to a serious incident, injury or death.

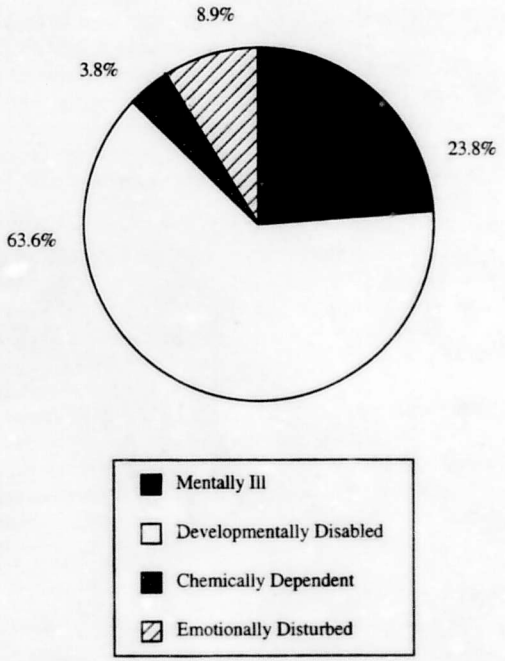
Safety Issues

There have been cases that involve safety concerns such as harmful substances environmental hazards transportation services etc. There are safety officers at all RTC's and the MRS has recommended that the Safety Officer be part of the investigation whenever a serious injury, incident or death raises a safety concern.

Lethal Weapons

There have been a number of death reviews that involve the use of a lethal weapon. In one case the weapon was stolen from a staff person and in other cases the weapon was in the household where the death occurred. We hope to work with the Department of Human Services to establish some way of alerting staff and families of clients to the potential danger of having these weapons.

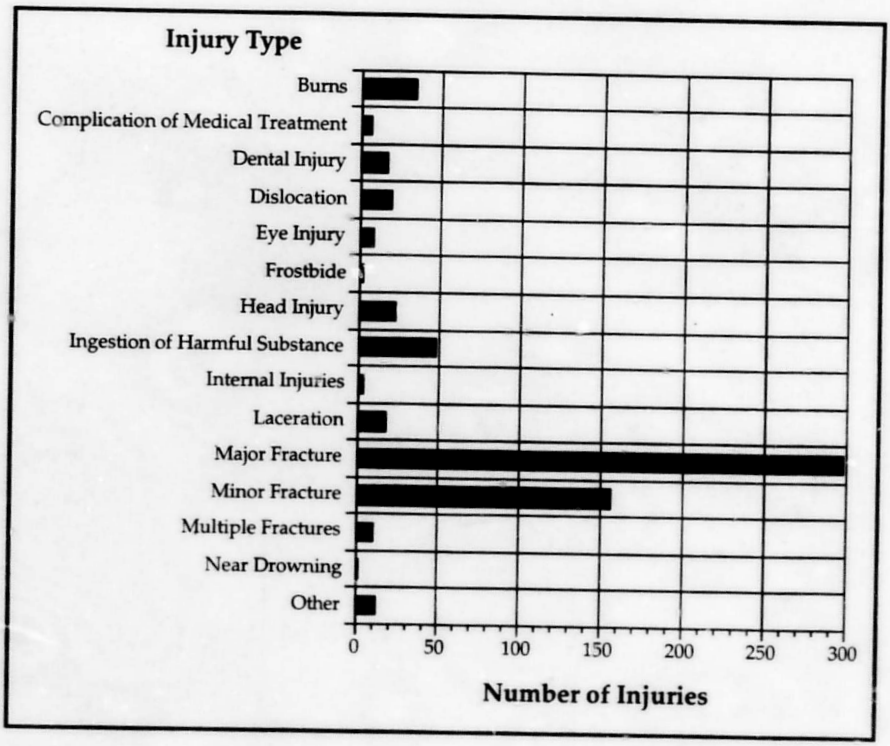
Serious Injuries by Disability



DISABILITY	FY 92	FY 93
Mentally Ill	28.0%	23.8%
Developmentally Disabled	60.0%	63.6%
Chemically Dependent	3.0%	3.8%
Emotionally Disturbed	10.0%	8.9%

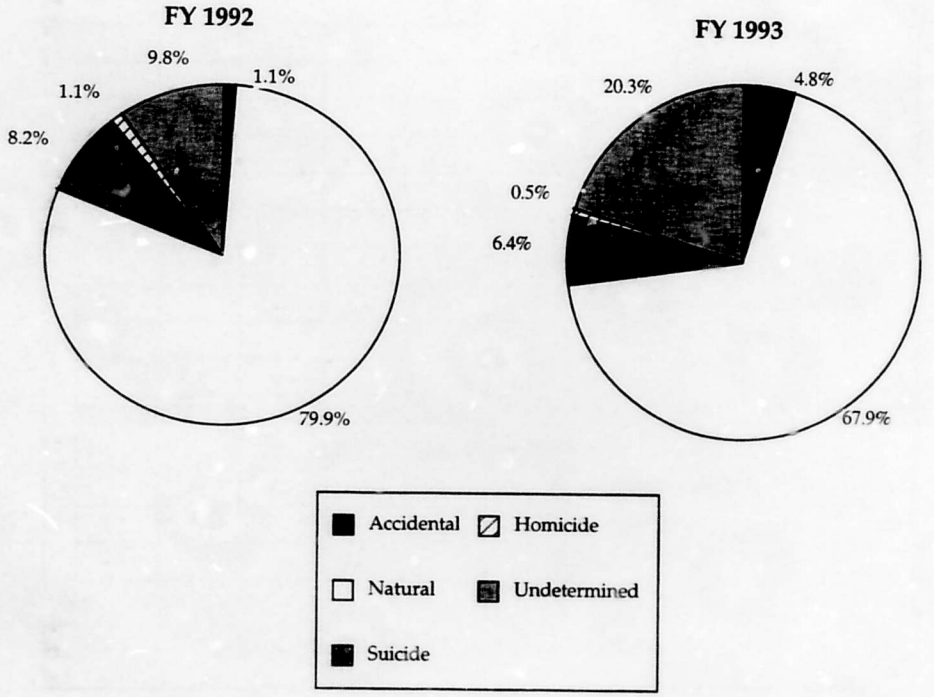
The percentages of reports of serious injuries by disability has not varied enough over the years to be of any significance. Developmental disability continues to be the group with the largest percentage of serious injuries and that corresponds with the number of persons in that group who are receiving services.

Serious Injuries by Injury Type



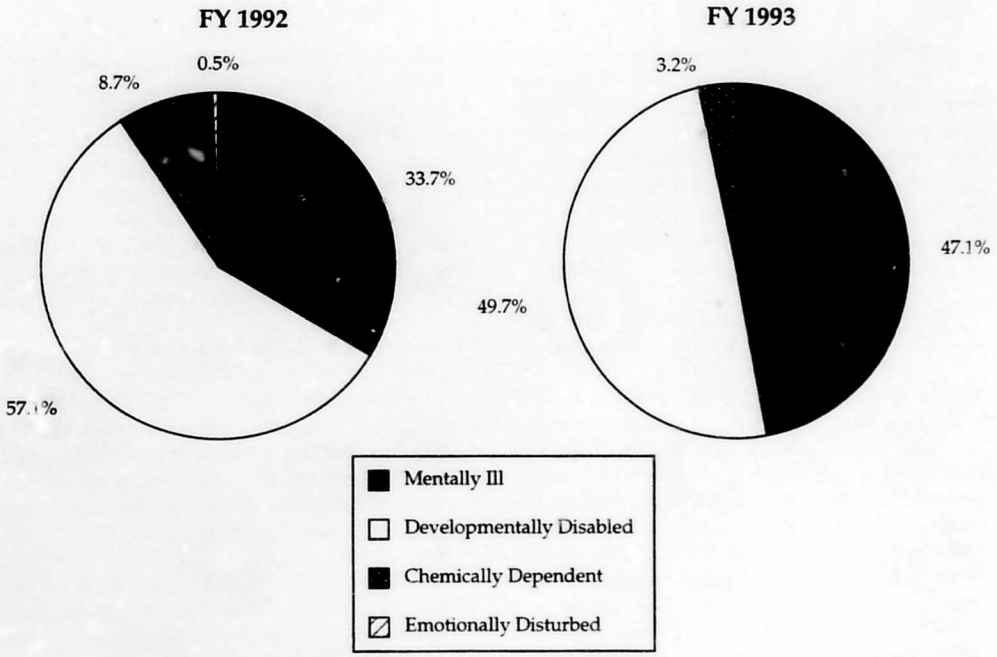
Fractures consistently dominate as the most frequent type of serious injury. The fractures are most often caused by falls.

Deaths by Death Type



The total numbers of deaths reported to the Office have remained constant over the years. When the deaths are broken down by the death type the percentages change somewhat however all the types stay in the rank order from year to year. Accidental deaths had the largest increase of any of the types. The undetermined group seems too high and there will be an effort to determine why that number is so high and what can be done to lower it.

Deaths by Disability



This is the first year that we can report that less than half of the death reports involved a person with a developmental disability. Prior years showed over 50% were of persons with developmental disability. There were no reported deaths of emotionally disturbed children in fiscal year 1993.

Ombudsman Advisory Committee

The Ombudsman Advisory Committee is comprised of 15 members appointed by the governor for a period of three years. Each member appointed is selected based on their expertise, knowledge, and interest in the disabilities of mental illness, developmental disabilities, chemical dependency, and emotional disturbance. Geographic location is also a consideration for membership to insure representation state wide

The role and purpose of the Advisory Committee is to provide assistance to the Ombudsman in fulfilling the Office's mandate to "promote the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance." In assisting the Ombudsman, the committee provides input and gives direction to issues and concerns that impact the quality of consumers services. For example, the committee has provided input in the development of Office policies and procedures, provided direction in the formation of Office goals and objectives, and provided recommendations to improve the service delivery system. They also serve as an extra set of eyes and ears to the community.

In 1993, the Advisory Committee was very active in assisting the Office in continuing to further define its goals and objectives. A smaller group of the Advisory Committee was formed, the Design Group, to assist in defining more specifically who are the Office's external and internal consumers, to develop an internal quality improvement mechanism to measure the activities of the Office, and to develop a mechanism to identify system wide problems that impact consumers.

Developing a working relationship between the Advisory Committee and the Ombudsman Staff is an important component in the success of implementing new ideas and strategies. Because of the composition and dedication of the Advisory Committee and Ombudsman Staff, the vision for improving the lives of consumers has been a shared and unified vision.

For 1994, the Design Group plans to assist the Ombudsman staff in developing an internal quality assurance and quality improvement plans. These plans will provide the Office with measurement tools to evaluate how effective the Office is in delivering quality and the desired services to consumers.

Design Group Meeting

Advisory Committee Membership

Lori Squire - appointed 5/92 to 1/95 as a quality assurance and risk management expert. Currently the chairperson for the Advisory Committee and serves on the Medical Review Subcommittee.

Charles Bates - appointed 4/93 to 1/96 as an Organizational Development Specialist assisting organizations and individuals to develop new skills or enhance existing ones.

Patricia Commerford - appointed 4/93 to 1/96 a as community volunteer representing the interests of persons with disabilities.

James Dahlquist - appointed 4/93 to 1/96 as a attorney representing persons with mental illness and chemical dependency. He also has extensive human services experience.

George Dorsey - appointed 5/92 to 1/95 as a psychiatrist. Serves as chairperson of the Medical Review Subcommittee.

Charles Fields - appointed 10/92 to 1/94 as a licensed psychologist with extensive experience in working with persons with mental illness and developmental disabilities.

Jane Klingle - appointed 5/92 to 1/95 as a representative on state and national boards and committees for persons with mental illness .

Jennifer Olson - appointed 6/91 to 1/94 as a physician of internal medicine. Also serves on the Medical Review Subcommittee.

Jan Pettus - appointed 4/93 to 1/96 as a representative on boards and committees for persons with mental illness.

Scott Raberge - appointed 6/92 to 1/95 as a representative for persons with developmental disabilities .

Katharine Reynolds - appointed 4/93 to 1/96 as a consultant who assist organizations in developing healthy working relationships.

Beth Riesgraft - appointed 4/93 to 1/94 as a family physician.

Marilyn Vigil - appointed 8/92 to 1/94 as professional with extensive experience in providing services to persons with mental illness.

Janis Amatuzio - appointed 12/92 to 1/94 as a forensic pathologist with a special interest in patterns of injury in child abuse. Also serves on the Medical Review Subcommittee.

Leena Devaraja - appointed 3/93 to 1/96 as a certified pathologist.

1994 Operational Priorities

- Continue to serve as an intermediary between citizens and government or government regulated services for persons with mental disabilities.
- Continue assistance of clients and families to insure fair treatment during the process of downsizing of the Regional Treatment Center system.
- Continue to advocate for fair and reasonable health care system access for persons with mental disabilities in light of proposed changes in the health care delivery system both nationally and in the state of Minnesota.
- Continue to focus on the issue of Out of State Placement of Children with emotional disturbance.
- Work to establish a quality assurance program relating to the service provided by the Office of the Ombudsman.
- Improve client and community outreach.
- Increase consumer focus.
- Establish a client satisfaction survey.
- Continue participation on the task force charged with evaluating and improving Minnesota's Vulnerable Adult law.
- Continue participation on the Mental Health Task Force charged with making recommendations on the future of the mental health system in Minnesota.
- Work to establish partnerships with the community based programs and advocacy organizations to enhance resources available to consumers while minimizing duplication of effort.
- Work to establish an Ombudsman's Roundtable to improve communication and cooperation with other ombudsman functions within the state in order to prevent duplication while sharing available technical expertise.

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:

(1) 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:

(1) 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, 1994.

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