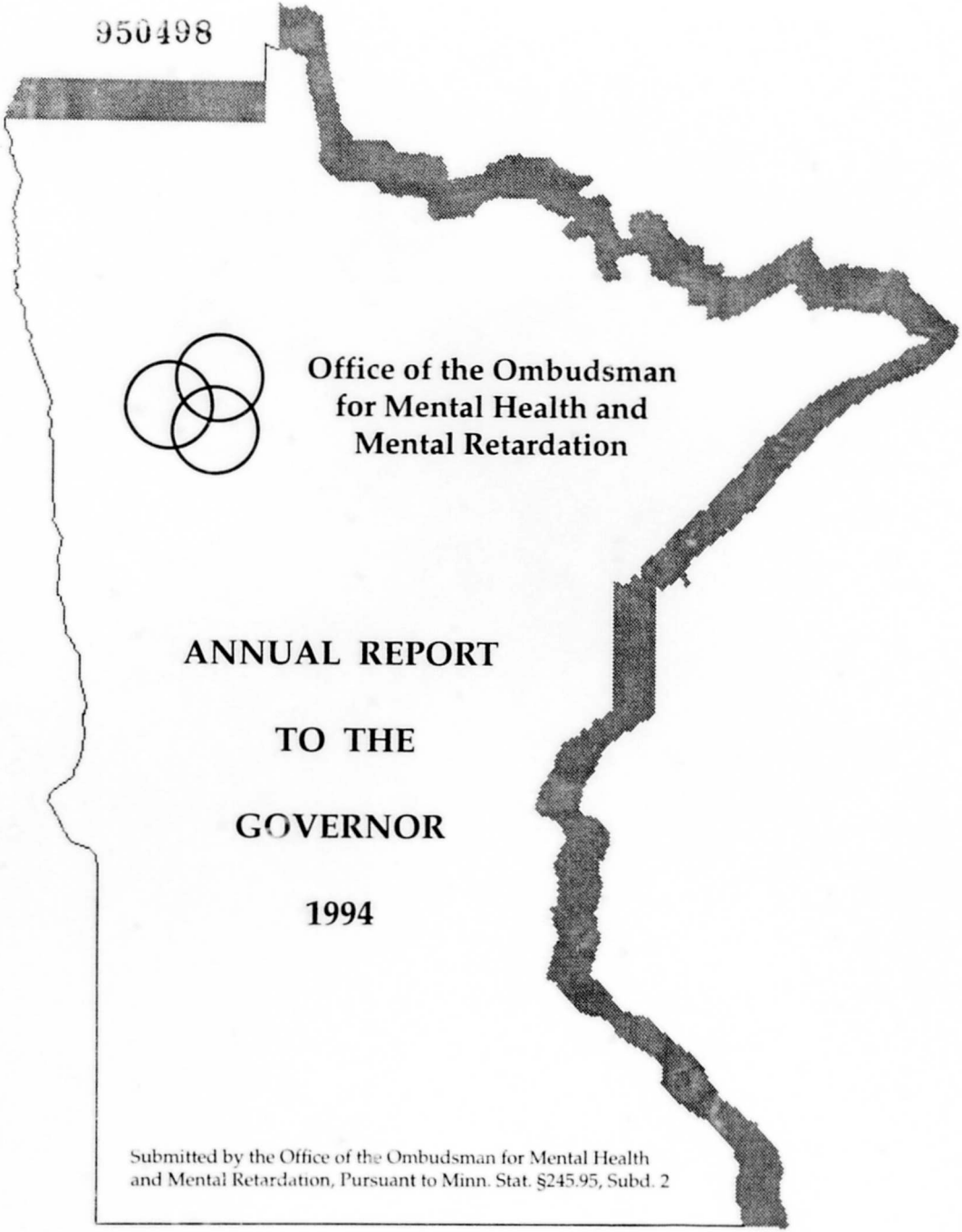

Office of the Ombudsman
for Mental Health and
Mental Retardation

ANNUAL REPORT

TO THE

GOVERNOR

1994

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

121 7th Place E. Suite 420, Metro Square Building, St. Paul, MN 55101-2117
612-296-3848 or Toll Free 1-800-657-3506
TTY/TDD - Minnesota Relay Service 612-297-5353 or 1-800-627-3529

December 30, 1994

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 1994 to December 1994.

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 1994, 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, 1993 through June 30, 1994. 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

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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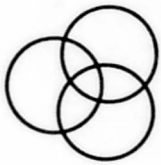

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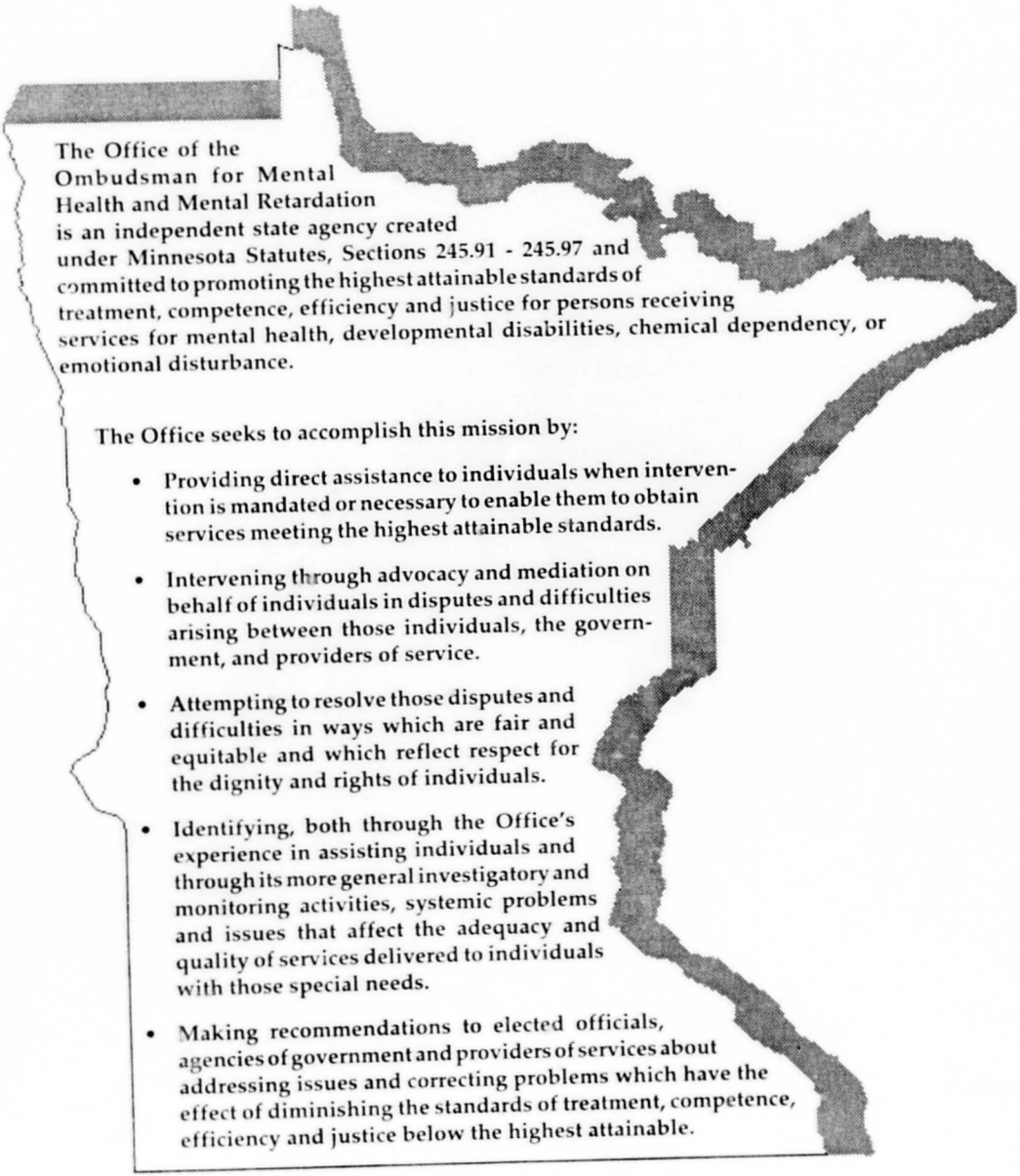
Ombudsman Office Mission Statement



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.

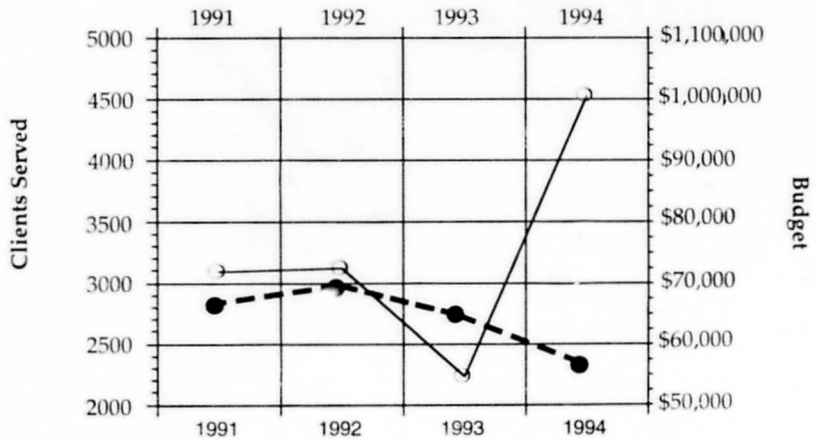
Preface

In our 1993 report, much time and attention was devoted to the reorganization efforts undertaken by this office. In 1994, the agency was able to use that new structure and focus on refining the new structure into a smooth operating process.

During 1994, we started the year by spending time at the legislature discussing the continuation of our advisory board and some supplemental appropriation needs. Both the governor's office and the legislature supported these efforts, however due to other circumstances the bill did not receive the Governor's signature. The members of the agency rallied around the supplemental appropriation loss and continued to pitch in to do the work of the agency without the budget necessary to serve our clients. Some staff continued to volunteer to take unpaid leaves of absence, defer equipment needs and to forego training needs. While the agency has been able to live within it's budget, our reduced staffing level has left some client related concerns unaddressed. Related to this, the staff of the agency participated in a number of stress reduction and wellness activities, in an effort to take care of themselves in order to continue to more effectively handle the large volume client contacts. The following chart provides a graphic view of this problem.

In 1993, we outlined a series of 12 priorities for the coming year. I am pleased to report that we have completed or made significant progress in all priority areas. A brief review of these priorities and their progress is contained in this report.

I am also pleased to report that Minnesota and this office were selected by the United States Ombudsman Association and the Agency for International Development through the Academy for Educational Development, as an education visit for training of the staff of the Russian Federation ombudsman's office. The group consisted of 11 key staff and computer specialists. The Russian ombudsman's office will be one of the largest in the



* Office Reorganization
* Time on Study Group/Strategic Planning
* Data Base Changed

**Increased Outreach

world based on legislation passed by the Russian Duma. The ombudsman was appointed by President Boris Yeltsin and works with the Commission for Human Rights. This office as well as the Office of Ombudsman for Crime Victim's and the Ombudsman for Corrections, were selected because of the work we do and because of Minnesota's commitment to citizen's rights as demonstrated through it's creation of specific specialty ombudsmen.

As we close 1994, we are preparing an aggressive legislative initiative for the 1995 session, in order to better serve clients in the future and to continue to promote the highest standards of treatment, competence, efficiency and justice for persons with mental disabilities.

I hope the report enlightens the reader on the work of this agency and helps to bring new understanding to those Minnesota citizens who live with mental disabilities.

Respectfully Submitted,

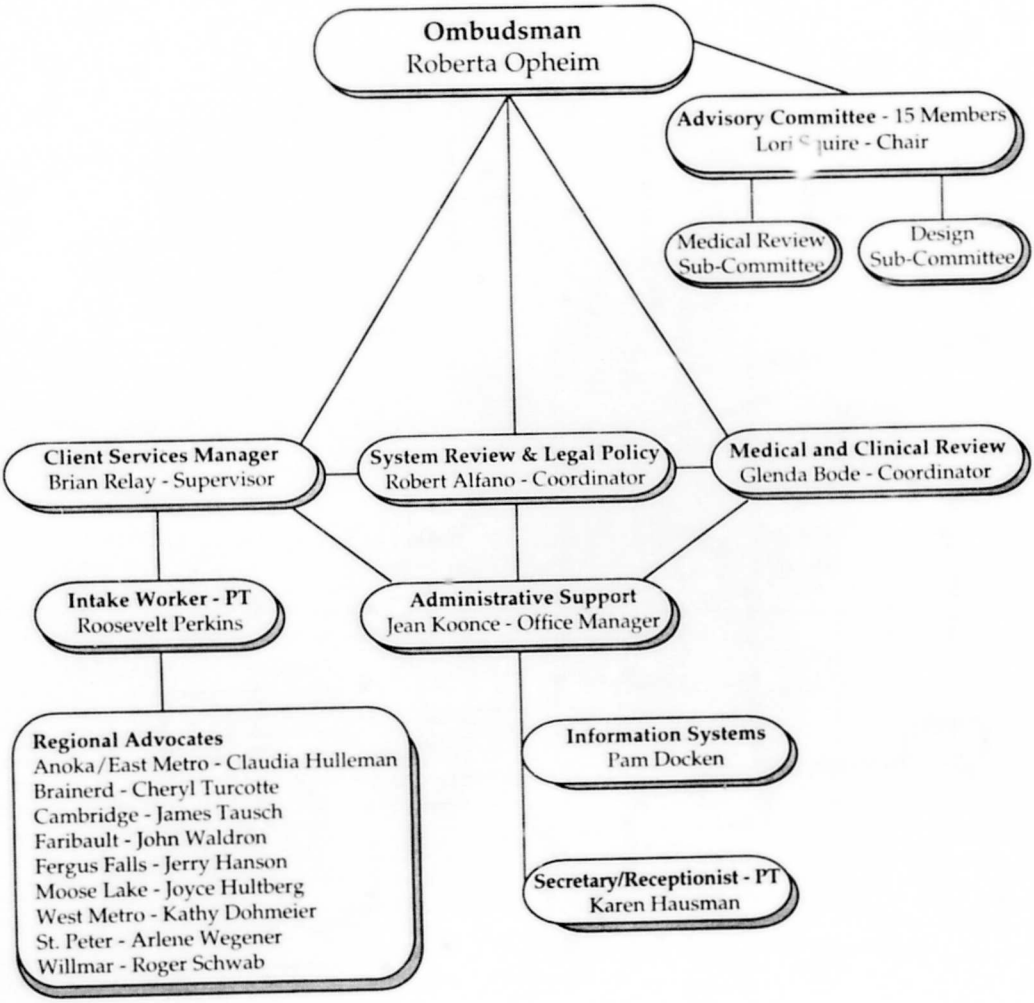
Roberta Opheim
Ombudsman

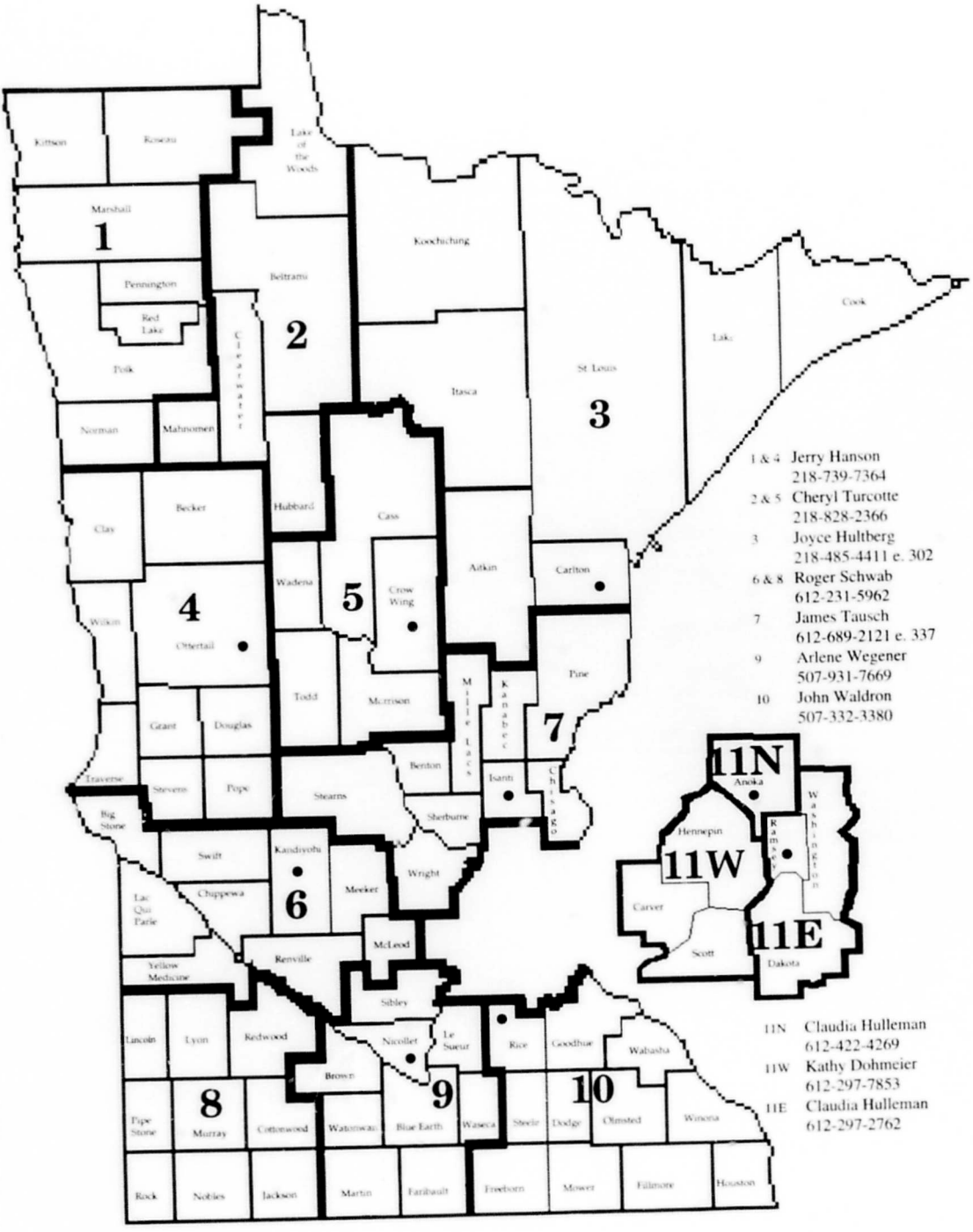
Honoring the Russian Federation at the Capitol Rotunda

Roberta Opheim, Ombudsman; Sheila Gottehrer, Representative of the United States Ombudsman Association; and members of the Russian Federation

Ombudsman Organizational Chart

as of December 30, 1994





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 Claudia Hulleman
612-297-2762

Advocacy and Mediation

The function of advocacy and mediation has always been and will remain a significant 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 receiving services, we are increasingly receiving requests from persons who live independently, are not receiving services, are mentally disabled and need assistance. We provide information, technical assistance and try as best we can to provide some help. People with mental disabilities face the same problems as the general population: crime, jobs, housing, and access to medical services; but they also face significant stigma, discrimination and exclusion.

During this past year we observed two needs that cry out for additional resources. The first priority is for our office to create a children's specialist who can devote exclusive time to the very special needs of children with emotional disturbance. Increasingly, we see the "tip of an iceberg" relative to children's issues in mental health, chemical dependency, corrections and child protection. The other area is public benefits. This area is not clearly identified as a service we should be providing. However, we are increasingly fielding calls concerning access to public benefits, housing or medical care. This area is very complicated, full of rules and regulations. It is constantly changing, and as funding at all levels of government continues to shrink, the impact on persons with mental disabilities will become critical. We would like to create a benefits specialist who by experience and training could assist mentally disabled persons to gain access to benefits that are rightfully theirs, and are essential to meet basic common human needs with dignity and compassion.

COOPERATIVE EFFORTS

1. A 56 year old woman with developmental disabilities was forced out of her home by the county case manager and taken to a regional center for temporary care. She was brought to the regional center in handcuffs in a police car. The reason for her removal was because her home was in need of repair and without the repairs her home would be condemned. The case manager felt that the client needed be removed so repairs to her home could be completed. However, several weeks prior to this incident, the client had worked with a county ARC advocate, and a plan was developed with the case manager that would have allowed her to stay in a motel until repairs to her house were completed. The case manager felt that at the last moment this was not an appropriate plan. The Ombudsman Office got involved and with the assistance of legal services, a conciliation hearing was scheduled. After the hearing, the client received a new case manager and was released from the regional center and returned to her home.

2. The Ombudsman Office in cooperation with a regional center administration investigated a research project that failed to follow state and regional center policy and procedure for the protection of research subjects. The research was on the use of the efficacy of rectal valium to control status epilictus and involved 23 clients from the regional center. The staff involved in the project failed to get appropriate and legal consent from the research subjects and allowed the physical examination of at least six subjects without prior legal consent. The results of the investigation led to disciplinary actions and revisions of the regional center's policy and procedures on the use of clients in research projects. Further, the regional center undertook a retrospective review of all its out-

standing research projects to insure that they were in compliance.

IN SEARCH OF HIGHER STANDARDS

1. A county human service agency contacted a regional client advocate with the Office of the Ombudsman, raising concerns about a Rule 38 program's internal policy on reporting and investigating abuse and neglect of clients. The client advocate investigated the situation and found that a female client alleged that she was sexually touched by a temporary employee at the work site. It was also discovered that the alleged perpetrator had shown up at the client's residential program at night looking for her. While these incidents were reported to the county, the Rule 38 program's internal policies and procedures were found to be deficient by the Client Advocate. The training and information provided employees by the Rule 38 was outdated. They failed to do a comprehensive internal investigation as required under rules; and, they failed to take appropriate action to insure the safety of the client. A report was written with recommendations and sent to the Rule 38. All the recommendations were implemented and further, the Rule 38 worked cooperatively with the county human services to insure compliance of rules and safety of clients.

ACCESS TO SERVICES

1. A child suffered a serious injury at an Intermediate Care Facility for the Mentally Retarded (ICF-MR), which was reported to the Ombudsman Office. The regional Client Advocate contacted the parent as part of an investigation. The parent was very upset with the lack of quality of services being provided to her son. She asked for assistance in getting waiver services so she could bring her son home to live with her. The Client Advocate contacted the case manager and requested that the client be removed from the ICF-MR and placed under waiver services with his mother. A conciliation meeting was scheduled and it was agreed that in-home waiver services would be provided and the client sent home within ninety days. The agreement included modifications to the mother's home so it would be handicapped accessible and adaptable for her son. Respite care and personal care services were also designed and approved. The client was returned home within the ninety days and is doing well.

2. A client with developmental disabilities was faced with loosing his work program, because it was not a licensed Rule 38, but a supportive employment program (SEP). Under the waiver (Rule 42), only a licensed Rule 38 can be reimbursed with M.A. funds. The client had been working with this SEP for two years and had made great strides in becoming more productive and independent. The county wanted to transfer the client to a Rule 38 so it could bill the cost under the waiver. Otherwise, the county was responsible for the funding of the SEP. The guardian of the client, who was his sister, was opposed to any changes in his work program. With her permission, the Client Advocate requested a conciliation hearing. The hearing was scheduled and it was decided that the county would continue to pay for the SEP until such time as the client needed a change in his work program. The client continues to do well.

3. A regional Client Advocate received a phone call from a client in jail who requested assistance in getting case management services for mental health. The client had a history of mental illness and chemical dependency. A referral was made to the county by the Client Advocate on behalf of the client. The client qualified for services and with the assistance of the Client Advocate appropriate placement for the client's chemical dependency was made. Further assistance by the Client Advocate included appealing a denial by Division of Rehabilitation Services (DRS) for job training on behalf of the client. DRS then found job placement for the client in a supportive employment work site. The client is now living in the community in his own apartment.

4. A parent with a child diagnosed with alcohol fetal syndrome contacted a regional Client Advocate requesting help in getting appropriate ser-

vices for her child. The Client Advocate explained the process for obtaining case management services for persons with developmental disabilities. The parent applied for these services and initially the county determined that the child qualified. However, after a waiver screening was denied by the Department of Human Services (DHS), the county informed the parent that it would terminate case management services to the child. The regional Client Advocate, with approval from the parent, requested a conciliation hearing to request that the county continue with these services even though the waiver was denied by DHS. An informal conciliation meeting was held and it was decided by the county and DHS that the county would continue to provide case management services and that a comprehensive evaluation of the child be completed. Based on this evaluation a decision will be made by DHS on whether the child qualifies for waiver funding.

5. A parent with a child diagnosed with severe emotional disorder contacted a regional Client Advocate to ask for help in getting appropriate services under the Children's Mental Health Act. Although the parent had made application with the county for these services, little had been done by the county to insure services as provided under the act. The Client Advocate contacted the county and a meeting was scheduled to discuss the issues raised by the parent. At the meeting a new case manager was assigned and a comprehensive Individual Family Service Plan (ISFP) was developed. This included respite care, crisis services, counseling, and parent and family education. The child remains with the family under this plan.

6. A regional Client Advocate was contacted by a family whose child was in residential treatment for evaluation and assessment of an emotional disturbance. The family requested assistance because they were fearful that the county would deny further funding for treatment and would send their child to a regional treatment center. The Client Advocate met with the client, reviewed records, and attended two meetings of the county's Family Preservation Committee. Initially, the committee decided that the client was at the residential program strictly for evaluation and that the county did not have the resources to approve treatment at that program. However, based on further information and recommendations from the residential program, the Committee decided to fund treatment for no longer than 90 days. The client has completed treatment and is now living at home.

7. The mother of a 17 year old Attention-deficit Hyperactivity Disorder (ADHD) child contacted a client advocate to request assistance with an appeal she had filed with her local social service agency. The mother had applied for case management services for her child, and had been denied. After reviewing pertinent records and meeting with school personal, the client advocate prepared an appeal argument based upon the "related condition" requirements of the statute/rule. Although the outcome of the appeal hearing was not favorable for the mother and child, it was still a time of increased growth and knowledge on their part. They understood more clearly what option/services would be available and how to access them.

CONFLICT RESOLUTION AND MEDIATION

1. A regional center administrator requested the services of the Ombudsman Office to help resolve a dispute between the regional center and the Department of Natural Resources (DNR). The problem was that the deer population on regional center land had become too large. The deer were starting to cause ecological harm to the nearby nature center. DNR wanted to open the area to deer hunting. However, the regional center administration was quite concern about this proposal because of the highly vulnerable individuals who resided at the center. A meeting was scheduled with the DNR, the regional center administration, and the Client Advocate to address the issue. Although alternatives were proposed, such as relocation of the deer and hunting limited to only sharp shooters in the morning, none of these proved to be feasible by the parties concerned. The Client Ad-

vocate outlined the vulnerabilities of the clients and the need to insure safety under the Vulnerable Adult Act. It was decided that there was no easy resolution to this problem but, for the present, no deer hunting would take place on regional center property.

2. A parent whose child was in a residential treatment program for emotional disturbance contacted a regional Client Advocate and expressed many concerns about the program and the program's lack of responsiveness to her questions. The Client Advocate worked closely with the parent and provided her with methods to address her concerns with the program. However, these methods turned out not to be satisfactory and the program continued to be unresponsive to the parent's questions and concerns. The Client Advocate then contacted the administration of the program and requested a meeting with administration and the parent to resolve these issues. At the meeting the parent talked about her concern with the family therapist, a lack of responsiveness from staff to her questions, a lack of patient education, especially on medications, for her son. The administration was willing to change the family therapist and that they would investigate the other issues raised by the parent and make changes as necessary. Although the parent felt that the program was more responsive after Client Advocate intervention, she still had concerns about the treatment of her son.

3. A client advocate was contacted regarding problems that had developed when the guardian of a Developmentally Disabled (DD) individual had removed the person from a licensed foster home, and had placed them with a friend. The friend's home was not a licensed foster home and there were numerous complications in the placement. Neither the servicing county nor the county responsibility were in favor of the new placement. After numerous contacts with the involved parties, and a review of pertinent records, the client advocate attended a meeting to try and arrive at a workable plan. All positions were clearly explained and a tentative plan was developed. The servicing county agreed to proceed with licensing the new home and additional resources for supervision in the home were explored. The new placement was allowed to continue and all parties involved appeared satisfied with the outcome.

PUBLIC REPORT

1. A former employee of a residential facility contacted the client advocate at one of the Ombudsman's regional offices. The initial concern reported was whether or not a vulnerable adult report was being appropriately followed up on and investigated by the agency who received the report. In the course of following up on this concern, the client advocate received multiple concerns from several persons and agencies describing ongoing and serious problems with the facility. These reports also included the concern that the actions taken to date by the regulatory and protective service agencies had not resulted in any substantial or lasting improvement in conditions and services at the facility.

A full review of this facility and related concerns was undertaken under the Ombudsman's mandate to promote the highest attainable services and to monitor the extent to which state and county quality assurance mechanisms protect the health, safety, and welfare of clients. This review included extensive gathering and review of records and data, interviews with a wide range of concerned and involved persons, and site visits at the facility. Following the review, a report was made to the facility's administration which included recommendations for improving services. When it became apparent that the facility's administration would not be making any substantive or lasting changes to improve services or conditions at the facility, the Ombudsman notified the Governor that a public report was warranted.

The Ombudsman's public report and other concerns regarding the facility were reviewed by state media services. Within a month after the report was released, in-depth reviews of the facility were being conducted by licensing, regulatory, and pro-

tective services agencies. Shortly thereafter the facility's administration agreed to place the program into voluntary receivership. Within seven months after the release of the Ombudsman's public report, all the clients who had formerly resided at the facility were living in more appropriate placements and the facility was closed.

OPENING COMMUNICATIONS

1. A professional therapist contacted a client advocate to report that a client was stating that she had been transferred to a lower paying job after reporting physical harassment by a peer. The review by the client advocate found that in the client's new job she was receiving two paychecks per pay period. She had previously received all her pay in one check per pay period. Although she was actually earning more money in her new job, this would not be evident in comparing one paycheck to another. The client advocate found that the allegation of being transferred to a lower paying job after filing a complaint was not substantiated. However, the client advocate did encourage the client's job coach to meet with the client and review with her the amount she was earning and how this was being paid to her; a procedure the client reported had not been done at the time of her job transfer.

2. A young mother contacted a client advocate because her infant had been removed from her care by the local social service agency. She had been experiencing mental health difficulties, and had broken up with her boyfriend (the baby's father). Currently she believed she was functioning better and was back together with her boyfriend. However, she felt social services was making it difficult for her to expand her visiting times and to work toward regaining custody. After reviewing the social service file and having numerous conversations with the child protection worker involved, the client advocate attended a review/planning meeting. All issues were discussed and a plan was developed to expand the unsupervised visit times. Shortly after this revised plan was implemented, the mother decided to allow the involved foster parents to adopt the baby. She indicated this was a difficult decision, but one she felt was best for her child.

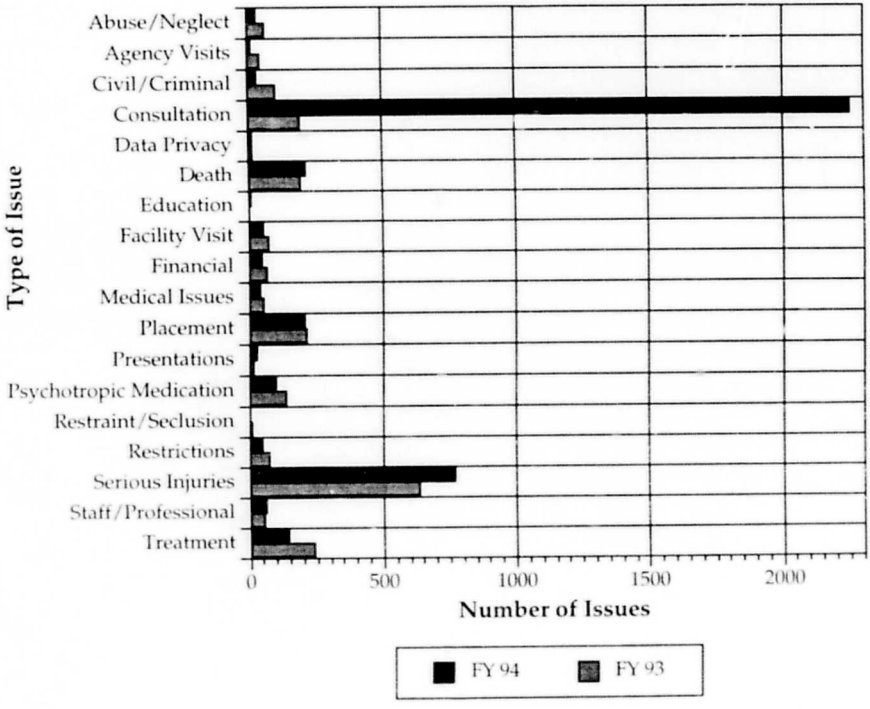
PROACTIVE ADVOCACY

1. One of the Ombudsman's regional staff was contacted and requested to review a proposed policy which would be highly intrusive for all new admissions. The client advocate contacted peers around the state and surveyed them as to how the concern which resulted in the proposed policy was handled at other facilities. After researching the issue and reviewing the proposed policy, the client advocate offered suggestions to mitigate the impact of the new policy and encouraged the development of criteria which would detail when the intrusive procedure would be used. The policy was subsequently amended so that not all new admissions would be subject to the procedure; only those who meet the criteria.

Brian Relay, Client Services Manager

Contacts by Issues

The graph demonstrate a comparison of issues between Fiscal Year 93 and 94. Most issue areas show a slight decrease or have remained consistent during the past year. However, there are two exceptions that require further explanation. The increase in reports of serious injuries has increased. We believe this reflects more on our continued efforts to provide outreach to residential service providers, rather than any increased risk to persons receiving services. We have placed additional attention during the past year to providing presentations and in-service training to providers and professional organizations. We have also increased our outreach at selected conferences that provide us access to consumers, professionals, service providers, and state policy makers.



The graph below illustrates the issue or activity in comparison between Fiscal Year 93 and 94 by number and percentage of overall activity.

Number of Issues

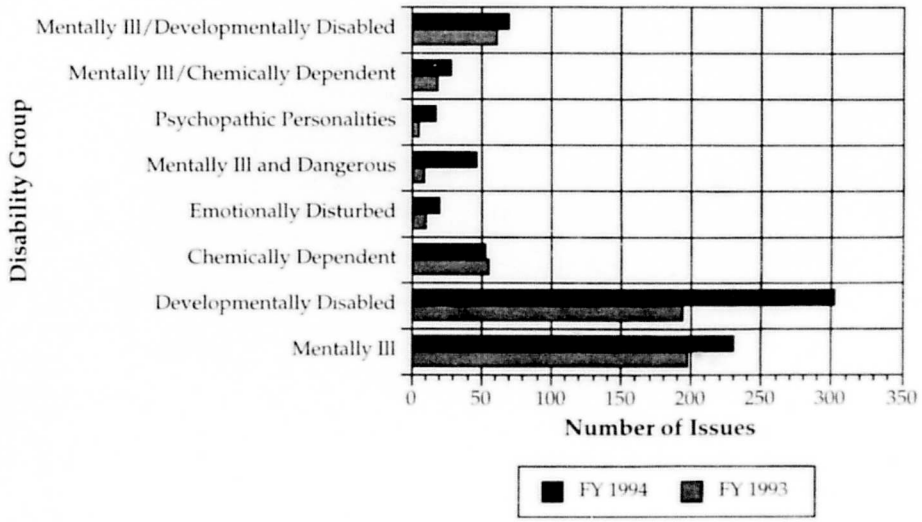
Type of Issue	FY 93	FY 93 %	FY 94	FY 94 %
Abuse/Neglect	64	2.9%	37	0.9%
Agency Visits	60	2.7%	12	0.3%
Civil/Criminal	104	4.7%	37	0.9%
Consultation	191	8.6%	2251	55.3%
Data Privacy	15	0.7%	13	0.3%
Death	193	8.6%	215	5.3%
Education	5	0.2%	7	0.2%
Facility Visit	95	4.3%	53	1.3%
Financial	68	3.0%	47	1.2%
Medical Issues	53	2.4%	41	1.0%
Placement	212	9.5%	208	5.1%
Presentations	24	1.1%	28	0.7%
Psychotropic Medication	137	6.1%	101	2.5%
Restraint/Seclusion	9	0.4%	4	0.1%
Restrictions	75	3.4%	44	1.1%
Serious Injuries	634	28.4%	769	18.9%
Staff/Professional	54	2.4%	59	1.4%
Treatment	240	10.7%	143	3.5%
TOTAL	2233	100.0%	4069	100.0%

Contacts by Disability

This graph demonstrates a fairly consistent pattern in regard to individual disability groups receiving services from the Office of Ombudsman. Individuals receiving services for Mental Illness or Developmental Disabilities continue to be our primary service recipients.

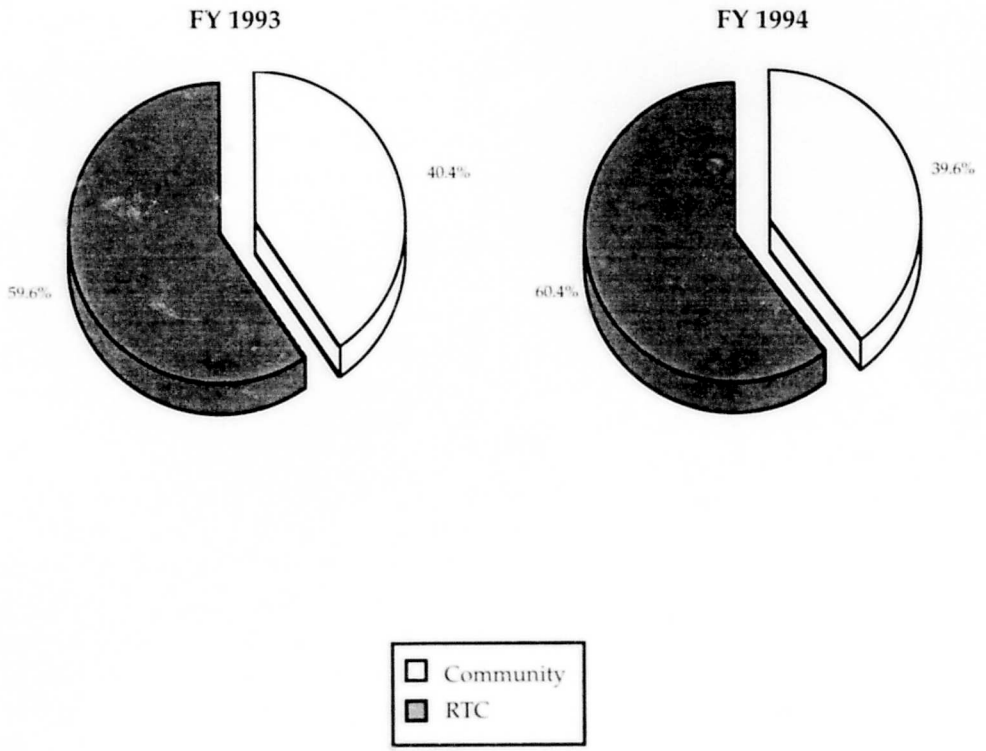
During FY 1994, we saw a dramatic increase in services to persons with Developmental Disabilities. This increase was anticipated as the State downsized large facilities in favor of smaller community based options. Residential options include small Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Adult Foster Homes, Semi-independent living options, and waivered services. Much of our service delivery to persons with Developmental Disabilities was in screening and monitoring the placement of individuals from regional treatment centers to community options.

One of our present and future challenges is to identify a rapidly growing community residential network. Minnesota's network includes corporate care providers, State operated community services, waivered services and adult foster homes. During this period of rapid change it is increasing difficult to identify service providers. We must assure that service providers are aware of death and serious injury reporting requirements and that our outreach efforts effectively reach both residential provider and persons with Developmental Disabilities in order to promote the highest attainable standard in the community as well as regional treatment centers.



Contacts by Regional Treatment Center or Community

During FY 1994, a slight increase in Regional Treatment Center contacts was noted, as demonstrated by the comparison graphs below. This slight increase in Regional treatment center contacts was anticipated due to increased activity in the state's downsizing of regional treatment centers at Moose Lake and Faribault and subsequent discharge of persons from regional treatment centers to the community. We actively monitored the placement and quality of services provided to former regional center clients.Another activity that increased our regional center contacts was our ability to devote more resources towards Minnesota Security Hospital and issues concerning the Psychopathic Personalities at that facility. Our continued goal is to provide a reasonable balance between services to regional treatment centers and community. We have moved more towards resolving systemic issues that will assist larger numbers of clients in a labor and cost effective manner.



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. 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 standards of care and treatment.

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 recommendations.

1994 Systemic Reviews

1. Legislative Task Forces

In 1994, a large part of the Office's systemic review was conducted through participation on several state and legislative task forces. Specifically, these task forces dealt with the following issues: Vulnerable Adults, Psychopathic Personalities, the Adult Mental Health System, and the Commitment Act.

A. Vulnerable Adults
B. Psychopathic Personalities
C. Adult Mental Health
D. Commitment Act

The Office is also involved with the Supreme Court Task Force on Civil Commitment. The Task Force, which the Office supported during the last legislative session, is reviewing the state civil commitment law, court rules and procedures and related legal and treatment issues, for possible changes in the system. The Office representative is a member of two sub-committees which are reviewing Patients Rights and Advocacy, and Judicial Process.

2. Federal Issues

The Ombudsman Office was also active on federal issues. The Office participated in the national debate on health care reform by issuing a white paper outlining the need for parity in mental health benefits. The paper was distributed in Washington by the chair of the Ombudsman Advisory Committee who participated in a White House Conference on Health Care reform. This paper was also sent to Minnesota's congressional delegation.

3. Monitoring Rule Changes

The Office was also active monitoring potential rule changes that would impact on the clients the Office serves. The Office argued against changes proposed by the DHS regarding Rule 47, Medical Assistance for the provision of medical equipment and supplies. The Office saw the changes, as written in the draft proposal, to be unfair and too restrictive regarding persons with disabilities access to equipment and supplies. As a result of these concerns, and those expressed by several consumers and advocacy groups, the DHS withdrew the draft proposal.

Another rule change that the Office expressed concerns over was the DHS proposed changes in their Surveillance and Integrity Review. The proposed changes would have unnecessarily classified as abuse "repeatedly obtaining health services for self-inflicted injuries or trauma." The Office felt that the changes would discourage persons with self-injurious behavior from seeking medical assistance, and would increase their stigmatization by labeling them as abusers of the system. Also another part of the proposed changes would have classified as abuse those who "repeatedly utilize medical transportation to obtain health services from providers located outside their local trade area." Again the Office felt that this section did not demonstrate a true understanding of the nature of mental illness, especially in small communities, where it is not always desirable to seek treatment in the person's home community due to stigmatization and other privacy concerns. After receiving many concerns about these sections, the DHS withdrew the section on serious injury behavior and modified the latter provision.

As noted above, because of the Office's direct involvement with the psychopathic personality population in Minnesota Security Hospital, the Office participated in discussions on revisions of DHS Rule 26.

4. Waiver Services

As part of an on-going review of the state's waiver system for persons with developmental disabilities, the Office surveyed counties as to how many clients were being served by waiver services, and what counties saw as their main concerns regarding the waiver system. The counties who responded expressed the following as their major concerns:

1. Problems with MMIS system
2. Limited and not enough enhanced funding
3. More Diversions needed
4. Inconsistent implementation throughout state
5. Waivers require more case manager time
6. Monitoring problems
7. More difficult to do respite care for children
8. Not enough total waiver slots
9. Long waiting periods
10. Waiver system is inflexible
11. System needs to be simplified
12. More difficult for people in the community to access
13. Conversions are difficult

The goals of the Ombudsman review is to examine the quality of services rendered, the sufficiency of existing rules and protections, the basic health care and safety of the recipient, the recipient's satisfaction of services, and the case manager's evaluation of overall quality of care compared to other alternatives. This will be a long term monitoring project.

5. Lakeview School

The Ombudsman's Office was contacted by the Governor's office to assist in mediating a complex process of transitioning a school in southern Minnesota that served children with special needs into a residential facility. Money had been authorized for a capital building plan but certain restrictions were placed on the funds. The school had operated under the regulations of the Department of Education, however, through this process it was determined that the facility should be required to meet licensing standards of the Department of Human Services for the residential part of the program. Because of the nature of the two different bureaucracies, the school was having difficulties in understanding what needed to be done and what was involved in the various funding streams. This left parents confused and concerned as to whether their child would have a place to go as many of the students had not succeeded in other traditional placement options. Through this process, the facility was educated on issues of compliance to meet DHS standards and a bill proposed to modify some of the original language and allow time for the facilities to be built according to the public policy guide of no more than four children in one residential facility and not the larger facilities that were originally proposed. This office will continue to work with individual students and their families as needed to ensure that their concerns are addressed as these students transition to the county case management system.

6. Lyon County Day Activity Center

This agency originally initiated an investigation into treatment of clients at this center based on complaints received from people in the community. During the preliminary process, the board of the DAC proposed changes in organizational structure that eliminated our need for a full investigation. The regional advocate in that area worked with the facility, families, the county and state agencies to facilitate a smooth transition and ensure that clients had the resources for day programming.

7. Regional Treatment Center - Client Smoking Policy

The System Review Coordinator from this agency worked in a collaborative effort with the Department of Human Services to ensure that the client focus would be considered in any policy development.

Medical and Clinical Review

The mandatory reporting of all client deaths and serious injuries became effective on August 1, 1989. Each year since that date there have been increasing numbers of reports made. We attribute this increase in reports to outreach by our office. One example of the outreach was a letter sent to all facilities, agencies and programs in October of 1993 reminding them of their responsibility to make the reports. It also defined what criteria were used to determine when to report. The letter prompted many calls from providers who hadn't been aware of their responsibility to report. We hope to continue to find ways to make the community aware of us and what we do. We encourage providers to call if there is a question regarding reporting. There is always someone who will be happy to answer questions.

We were able to include a "Medical Update" report in the 1993 annual report. The report was specific to deaths that had occurred in Detox facilities. There will be another report coming out soon from the office that compiles the information that we have gathered on suicide deaths reviewed by the Medical Review Subcommittee (MRS) over a two year period of time. **Watch for it.**

There were 215 deaths reported to the Office in FY 1994. One hundred twenty one (56%) were closed immediately. Fifty-nine cases (27%) required a full review by the Medical Review Subcommittee (MRS). The remaining 17% were open for a limited review and were closed by the Medical Review Coordinator after additional information was made available.

A letter is always sent to the reporter or other designated person after a death has been reported. The letter notifies the recipient that the death has been reported and if any additional information will be needed. If a case is not closed immediately, a letter is sent to notify the designated person when it is closed.

During the death review process there have been several questions raised regarding how the determination of suicide as the manner of death is made. The Medical Review Coordinator has met with the Ramsey County Medical Examiner in order to ask questions about that subject. The meeting was very helpful. The addition of a pathologist as a member of the MRS has been greatly beneficial.

Interagency cooperation

The Medical Review Subcommittee was asked to assist the Corrections Ombudsman by reviewing the circumstances surrounding the death of an inmate with mental illness. The MRS answered questions and made recommendations. This is an example of the spirit of cooperation that has developed with the establishment of the Ombudsman's Roundtable.

Glenda Bode, Medical Review Coordinator

Death Review Screening Indicators

- A death attributed to suicide while receiving services.
- A person who dies while receiving services and for whom Clozaril is currently prescribed.
- A death of a person with a diagnosis of Neuroleptic Malignant Syndrome.
- A person who dies of an acute* process in a non-acute setting.
- A person who dies in a detoxification unit.
- A death of a person receiving services that may be related to a delay or failure to diagnose and/or treat in a timely manner.
- A death that may be related to abuse/neglect.
- A sentinel case: Any death where the circumstance of the case do not meet the indicators for review but review is appropriate.**
- Any death of a child.

***acute examples:** bowel infarctions, pneumonia, heart disease, end stage COPD, blood dyscrasias, etc.

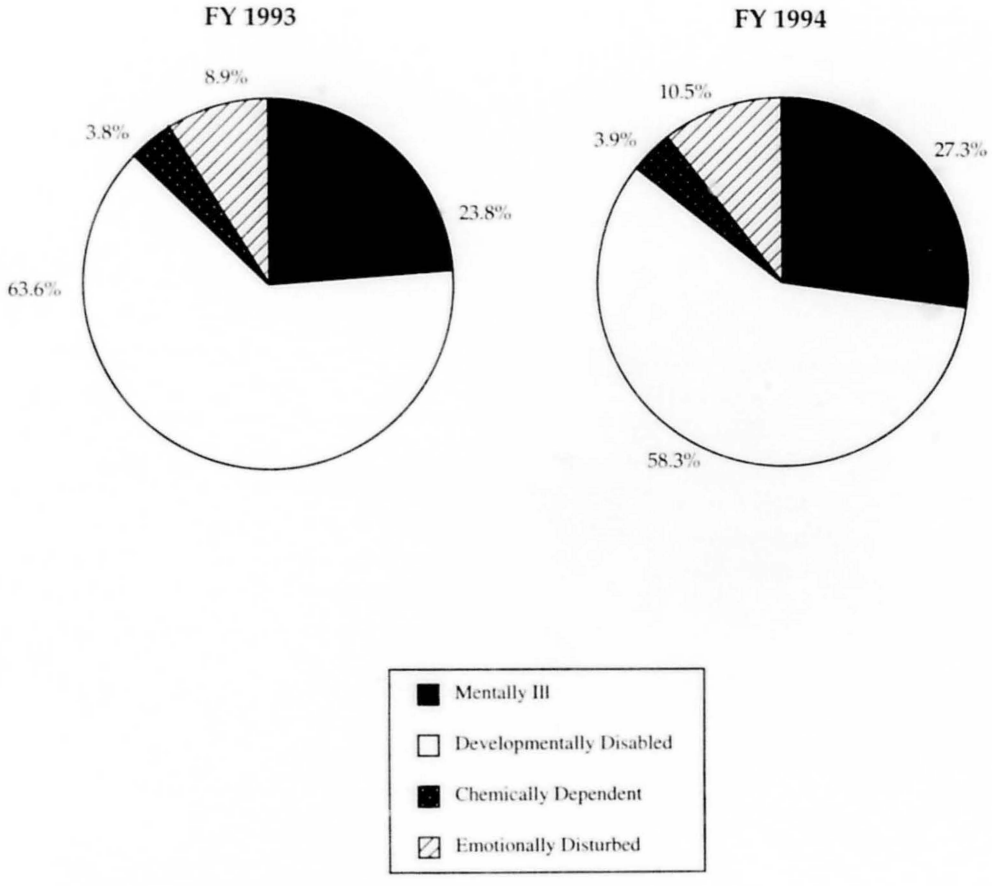
**Review requested by family members or other sources; concerns by Ombudsman staff or others, etc.

These death review screening indicators were established by the present Medical Review Subcommittee (MRS) in July of 1993. A death that meets any of these indicators will be prepared for full review by the MRS.

The last criteria (any death of a child) has been modified to have an initial screening by the Medical Review Coordinator to establish whether the death meets any of the other criteria. The reason for this modification is the large number of deaths of children reported where the child has been very seriously handicapped and has been expected to die for a period of time. The child may be residing in a foster home, in the natural parent's home or in a licensed facility. The report is made because the child is receiving case management services.

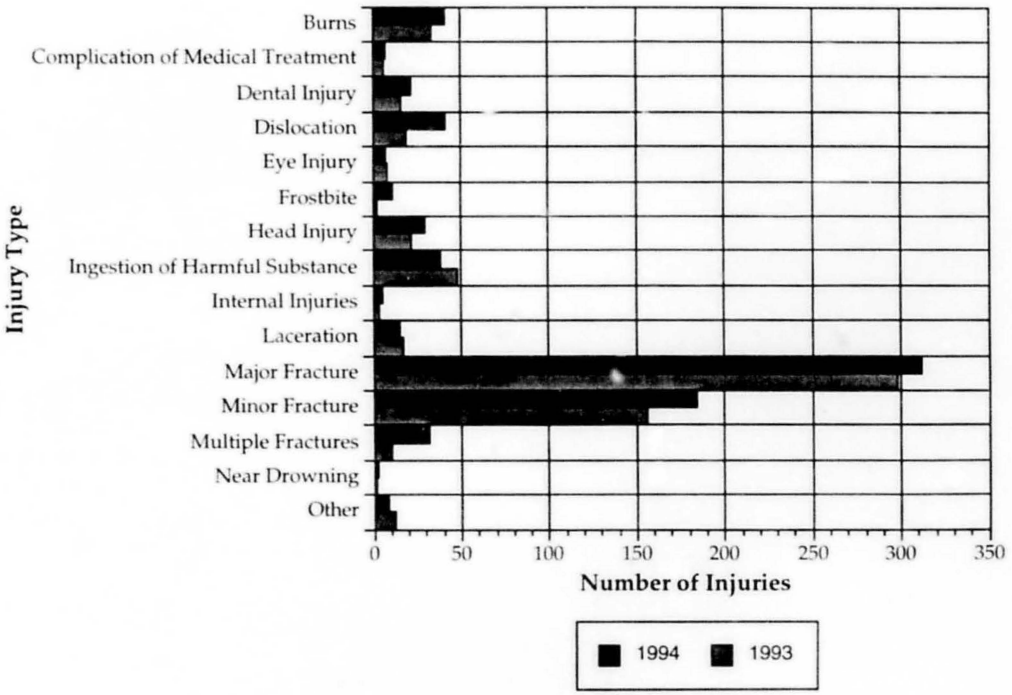
We have continued the review all deaths of clients who are taking Clozaril at the time of death. The Clozaril monthly report that is compiled by DHS has been reviewed by the MRS at the regular meetings. The report tracks the use of Clozaril in the Regional Treatment Centers. According to the report three clients have been forced to take Clozaril since we started monitoring.

Serious Injuries by Disability



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.

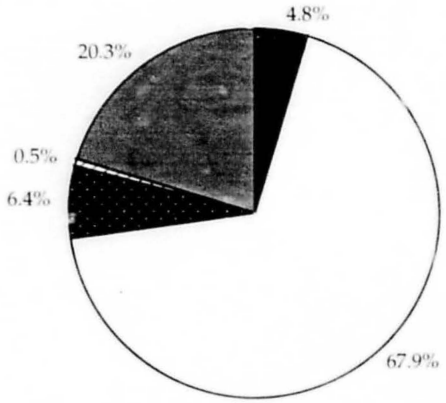
Serious Injuries by Injury Type



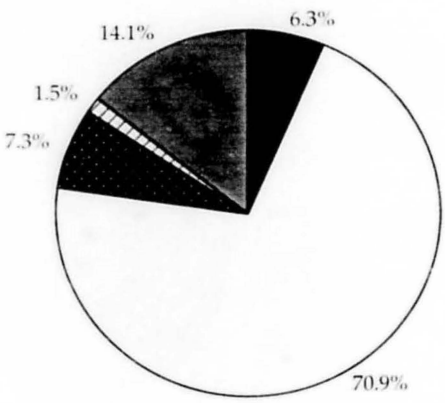
This graph illustrates the increased number of injuries reported in fiscal year 1994. Fractures consistently dominate as the most frequent type of serious injury. The fractures are most often caused by falls.

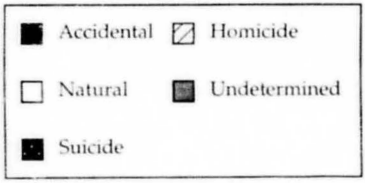
Deaths by Death Type

FY 1993



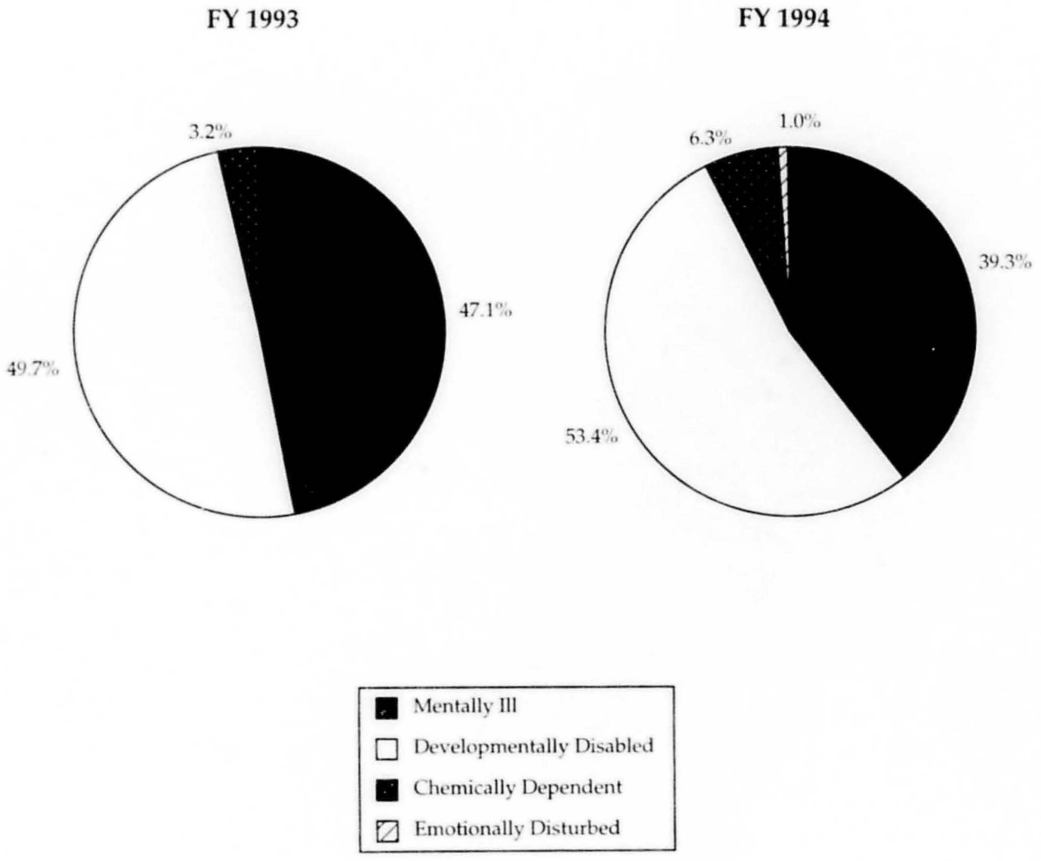
FY 1994





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. We have accomplished our goal to lower the percentage of deaths that have been coded as undetermined.

Deaths by Disability



These graphs have some variation, however, the fiscal year 1994 graph is more in keeping with fiscal years prior to 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 children with an emotional disturbance. Members bring experience from differing points of view from consumer to professionals and care providers. 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 and emotional disturbance." The Advisory Committee provides extra eyes and ears to what is happening in the community, and advises us on opportunities to improve delivery of services and identify gaps in the delivery system.

The Ombudsman Advisory Committee also has a five member medical review subcommittee charged with the review of deaths and serious injuries in residential facilities and programs that serve mentally disabled persons. This function is critical to assure that deaths of mental disabled persons are not caused by abuse or neglect. (See the medical review section of this report for further detail.)

Both the Ombudsman Advisory Committee and the Medical Review Subcommittee were to have expired on June 30, 1994. During the 1994 Session of the Minnesota Legislature a great deal of effort was put into gaining legislative approval to extend the life of both these important functions. Legislation was passed, however as an unrelated result of the Governor human services veto the measure was lost. The Governor, recognizing the benefit of both committees, and the potential for harm to persons with mental disabilities, signed an Executive Order allowing the Ombudsman Advisory Committee and the Medical Review Subcommittee to continue their beneficial work.

During 1994, the Ombudsman Advisory Committee has been busy with a constant variety of issues concerning both individuals and systems. The following are but a few examples of Advisory Committee activities:

Advisory Committee Meeting

- In May of 1994, Lori Squire, Advisory Committee Chair, was invited to a Health Care Reform briefing in Washington D.C. Not only did she bring valuable information back to advisory committee members, but Ms. Squire delivered a written statement of the advisory committee and Ombudsman's concerns about health care reform and persons with mental disabilities. (See attached copy of Washington Health Care Reform Letter.)

- During November 1994, the advisory committee was involved in hosting a group of Russian dignitaries who came to Minnesota to observe Minnesota's Ombudsman System. The Ombudsman for Mental Health and Mental Retardation and the Ombudsman for Corrections and the Ombudsman for Crime Victims took a leadership role in welcoming the Russian delegation, and providing a reception at the state capitol.

- During 1994, the advisory committee worked with the Ombudsman for Corrections in addressing issues concerning adequate mental health care in correctional settings. The dialog has begun between corrections and mental Health Advocates to provide a training package to corrections employees in identification significant mental illness and a better system to address those needs.

- The advisory committee addresses concern about children's mental health issues and specifically the out of home-out of state placement of children in residential setting. One South Dakota facility, in particular, raised concerns about adequate residential standards. The Ombudsman for MH/MR sent a letter to all Minnesota County Social Service Agencies to request that due caution be given before a child was placed in that facility.

- During last years legislative session, all out of state correctional placements of children needed a facility review to assure that standards were equal or greater than Minnesota standards. It is our hope that the same precautions now in place for children in correctional settings will soon exist for children with emotional disturbance in residential settings out of state.

- The advisory committee has an active interest in the legal and treatment developments concerning Minnesota's most dangerous sex offenders who are committed to the Minnesota Security Hospital as persons with psychopathic personalities. During August members of the advisory committee visited the Minnesota Security Hospital for an educational tour of the facility and meeting with the professionals who provide these services.

- During the year the advisory committee and the Ombudsman's staff have been actively involved with larger systemic concerns that have involved parents, communities and inter governmental partnerships to resolve larger regional or state wide issues. Reports and recommendations have been sent to a variety of interested parties in the interest of better government and open communications.

- The advisory committee has continued its commitment to building a quality improvement process that enhances our ability to meet a multitude of needs without loosing sight of the populations we serve. We strive to assure that consumers have a strong voice, and that issues, that we have authority to address, are addressed in a timely, client centered manner.

- The advisory committee has its finger on the pulse of what the issues are from a multitude of sources from out side government. The Ombudsman and her staff provide perspective from within government and state wide. Future challenges that face the advisory committee will be as varied as the changing political climate. Issues concerning judicial commitment and treatment of psychopathic personalities will be followed closely. Out of home placement and residential treatment of children and adolescent youths will continue to raise concerns. The future of quality medical care and a changing welfare system will surely provide challenges for the mentally disabled populations we serve. The advisory committee looks forward to an active, challenging, but rewarding year.

Advisory Committee Membership

Charles Bates - appointed 4/93 to 9/96 as an Organizational Development Specialist assisting organizations and individuals to develop new skills or enhance existing ones.

Patricia Commerford - appointed 4/93 to 9/96 as a community volunteer representing the interests of persons with disabilities.

James Dahlquist - appointed 4/93 to 9/96 as a attorney representing persons with mental illness and chemical dependency. He also has extensive human services experience.

Daniel Wade Davis, M.D. - appointed 9/94 to 9/96 as a medical examiner. Also serves on the Medical Review Subcommittee.

Leena Devaraja - appointed 3/93 to 9/96 as a certified pathologist.

George Dorsey - appointed 5/92 to 9/96 as a psychiatrist. Serves as chairperson of the Medical Review Subcommittee.

Joseph Hunter - appointed 9/94 to 9/96 representing persons of color with chemical dependency.

Jane Klingle - appointed 5/92 to 9/96 as a representative on state and national boards and committees for persons with mental illness .

Jennifer Olson - appointed 6/91 to 9/96 as a physician of internal medicine. Also serves on the Medical Review Subcommittee.

Rodney Otterness - appointed 9/94 to 9/96 as an attorney representing persons with mental disabilities.

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

Scott Raberge - appointed 6/92 to 9/96 as a representative for persons with developmental disabilities.

Katharine Reynolds - appointed 4/93 to 9/96 as a consultant who assist organizations in developing healthy working relationships.

James Richter, M.D. - appointed 9/94 to 9/96 as a psychiatrist. Also serves on the Medical Review Subcommittee.

Lori Squire - appointed 5/92 to 9/96 as a quality assurance and risk management expert. Currently the chairperson for the Advisory Committee and serves on the Medical Review Subcommittee.

1994 Operational Priorities Progress Report

- **Continue to serve as an intermediary between citizens and government or governmental regulated services for persons with mental disabilities.**

In 1994, the agency saw a large increase in it's requests for services. These requests came not only from individual clients and their family members but from agencies requesting our office to facilitate communications between agencies.

- **Continue assistance of clients and families to insure fair treatment during the process of downsizing of the Regional Treatment Center system.**

With the eminent closing of Moose Lake and Faribault Regional Treatment Centers, this office has worked both with the Department of Human Services as well as individual clients to ensure that the transition is a smooth one. In Grand Rapids this agency hosted a clients rights forum to discuss the transition. We have also participated in local town meetings where the State Operated Services were met with apprehension or resistance.

- **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.**

The Chair of the Ombudsman Advisory Committee went to Washington to participate in discussions of federal health care reform proposals. We met with representatives of the Minnesota Department of Health to discuss ombudsman services proposed in health care and we worked with the Ombudsman for Managed Care to discuss access to services as client issues were brought to our attention.

- **Continue to focus on the issue of Out of State Placement of Children with emotional disturbance.**

Worked with the legislature in 1994 to produce legislation that would require inspection by licensing agencies from Minnesota of out of state juvenile facilities prior to placing Minnesota juveniles in those facilities. These facilities will be required to meet Minnesota standards before a county can make a juvenile justice placement in the facility.

- **Work to establish a quality assurance program relating to the service provided by the Office of the Ombudsman.**

The agency has developed a consumer feed back questionnaire that will be used to measure consumer satisfaction with this agency. It will be implemented in 1995.

- **Improve client and community outreach.**

The agency increased it's visibility in the broader community by making presentations at conferences and other community forums. The regional advocate job description was rewritten to include specific facility visits so that clients and providers are aware of the services provided.

- **Increase consumer focus.**

This priority will always remain a high priority for the agency. All laws, rules, and services are reviewed for their effect on clients. In 1993 the agency focused on a restructuring of the agency, however in 1994 we were able to direct agency resources to client services.

- **Establish a client satisfaction survey.**

A survey instrument was developed and reviewed

by agency staff as well as the Ombudsman's Advisory Committee. Emphasis was placed on making the instrument clear and easy to respond to. The intent was not to focus on individual productivity of the advocacy staff but to focus on overall satisfaction as perceived by the client.

- **Continue participation on the task force charged with evaluating and improving Minnesota's Vulnerable Adult Law.**

This agency was active in extensive meetings to develop and improve the state's Vulnerable Act. This process was a major undertaking involving efforts to bring to consensus needed reforms to improve the system. The working group represented clients, providers, advocates, regulators, licenser, investigators, law enforcement, organized labor, prosecutors and defense attorneys. Literally thousands of hours were put into development of proposals. Despite the disparate views, a proposal for a major reform act was developed and presented to the legislature for the 1995 legislative session. This agency was pleased to be part of this process.

- **Continue participation on the Mental Health Task Force charged with making recommendations on the future of the mental health system in Minnesota.**

Of all of the agency priorities, this one has left us with the greatest disappointment of this past year. This agency participated on the task force established by the legislature to study and recommend changes in the adult mental health service delivery system. All parties came to the task with some optimism for an outcome. However, the size and the make up of the task force became too large an obstacle to overcome. The task force fluctuated between 85 and 95 members. Only five of those members were there to represent consumers and consumer family members. In addition there were various other parties who are stakeholders in the service delivery system including counties, community based providers, advocates, other state agencies, and the largest contingency, organized public labor with some 40 + members. A great deal of information and insight was shared between the parties and that had some positive effects. However, in the end, no one could agree on fundamental change. Stakeholders seemed concerned about any changes that might erode their place in the system. The task force was simply too large to arrive at any type of consensus for change. The biggest loser was the consumers. It is our belief that changes will be coming to all health care delivery systems whether we want it to or not. The task force had a chance to participate in directing that change and it failed.

- **Work to establish partnerships with the community based programs and advocacy organizations to enhance resources available to consumers while minimizing duplication effort.**

This agency worked with the Mental Health Association of Minnesota, ARC of Minnesota and the Disability Law Center to ensure that client issues were thoroughly addressed without duplicating resources. We will continue to do that in the future.

- **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.**

In 1994, there was a formal gathering of the Ombudsmen in Minnesota to form a roundtable. This organization helped to share ideas, information and resources to strengthen the voice of the citizen in the most efficient manner. The roundtable was able to respond to various proposals for citizen services in an organized manner. As a result of our organized roundtable, Minnesota was selected as a participant in training of the Russian Federation Ombudsman Program. Minnesota was also chosen as the sight for the 1995 Annual Conference for the United States Ombudsman's Association.

1995 Operational Priorities

- Continue to serve as an intermediary between citizens and government or governmental regulated services for persons with mental disabilities.

- Create a children's services specialist within the agency to focus attention and resources on children's issues within the agency.

- Work collaboratively with other agencies both within government and community based to improve the treatment of persons with mental disabilities.

- Implement the internal quality assurance program related to services provided by this office.

- Work legislatively to enact the proposed reform of the Vulnerable Adult Act.

- Continue to participate and provide consumer sensitivity to the Supreme Court Task Force on Civil Commitment.

- Review key systemic issues for impact on persons receiving services for mental disabilities including the effect of health care reform and managed care on mental health care service delivery.

- Work with members of the Ombudsman Roundtable to determine if opportunities exist to provide ombudsman services in a more efficient, cost effective manner.