State of Minnesota
The Office of Ombudsman for Mental Health and Developmental Disabilities
2014/2015 Biennium Report to the Governor

Ombudsman's Overview

The 2014/2015 biennium saw the continuation of a much increased workload due to work on a Federal Class Action law suit involving individuals who were clients of the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). The defendant in the lawsuit was the Department of Human Services (DHS).

At the beginning of Fiscal Year 2012 OMHDD became involved in what is known as the Jensen Settlement Agreement. The settlement agreement was the result of a Class Action lawsuit which was initiated after the OMHDD published a report in 2008 about the excessive use of restraints in the Minnesota Extended Treatment Program (METO), a program operated by DHS. The settlement provided compensation for those who had been subjected to restraints as well as requiring the state to make systemic improvements in care provision for individuals with developmental disabilities.

The agreement included a prohibition on the use of mechanical restraints and only allowed for the use of manual restraints in an emergency situation. It also mandated the state to develop an Olmstead plan based on the US Supreme Court's 1999 decision that ruled people may not be kept in an institution simply because less restrictive alternatives do not exist.

Due to the lack of progress by the DHS in implementing the Jensen settlement agreement, in July 2012 Federal Judge Donavan Frank ordered the appointment of a court monitor. The court appointed David Ferleger, an attorney from Pennsylvania, as the monitor. In addition the judge designated the Ombudsman for OMHDD, Roberta Opheim and Dr. Colleen Wieck, Executive Director of the Governor's Council on Developmental Disabilities as consultants to the court and all parties. This resulted in increased work for the OMHDD, as this assignment continued through Fiscal Years 2014-2015.

Partially as a result of the Olmstead Plan, significant progress was made in statutes and rules governing services provided to persons with disabilities. Minnesota Statute Chapter 245B was repealed and replaced with the implementation of Chapter 245D in 2014. Additional legislative changes during this time also affected the OMHDD.

After an 11 month transition period the use of punitive practices and procedures, such as seclusion and restraint, were prohibited. Beginning in August 2015 all providers were required to use positive supports in place of restrictive interventions. Providers were also required to report to the OMHDD whenever they used an emergency manual restraint. These reports are called Behavior Intervention Reports (BIRFs). There were 2,071 BIRFs received in FY14 and 8,587 in FY15.

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Inside this Report:

Client Services Overview

The client services section of the OMHDD is made up of eight Regional Ombudsman and one Regional Ombudsman Supervisor. This section handles the calls from clients or interested persons who may have concerns about services for the clients or questions about laws, rules or procedures. The client services section also reviews the serious injuries that are required to be reported to the OMHDD by licensed facilities or programs. Beginning in January 2014, all 245D-licensed Home and Community

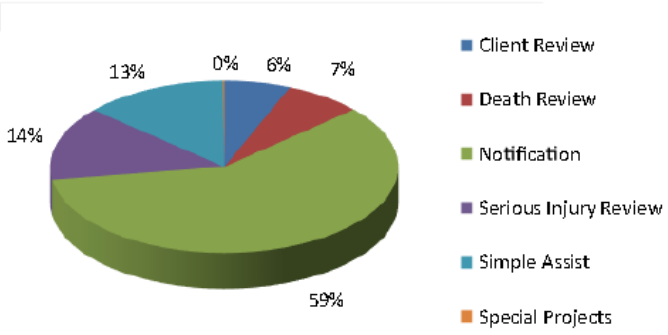
The issues with the greatest number of contacts that staff worked on were serious injuries, client rights and medical issues.

Cases By Type Of Issue	FY 2014	FY 2015	Biennium Total	Percentage (%)
Abuse/Neglect/Exploitation	202	162	364	1.94
Advance Directive	44	10	54	.29
Chemical Dependancy	256	246	502	2.68
Child Custody/Protection/Visitation	49	56	105	0.56
Civil Commitment	369	377	746	3.98
Client Rights	1,321	1,192	2,512	13.40
Criminal	54	50	104	0.55
Data Privacy/Client Records	61	10	71	0.38
Death	718	852	1,570	8.37
Dignity and Respect	601	502	1,103	5.88
ECT	6	3	9	0.05
Education System	28	21	49	0.26
Employment	28	26	54	0.29
Financial	128	73	201	1.07
Guardianship/Conservatorship/Rep Payee	448	377	825	4.40
Housing	160	139	299	1.59
Information	265	265	530	2.83
Insurance	71	51	122	0.65
Legal	116	103	219	1.17
Legal Representative	9	5	14	0.07
Managed Care	5	16	35	0.19
Medical Issues	966	863	1,829	9.75
Other Contacts	644	945	1,589	8.47
Personal Care Attendant	18	19	37	0.20
Placement	271	302	575	3.07
Psychotropic Meds	230	181	411	2.19
Public Benefits	85	96	181	0.96
Public Policy	51	15	66	0.35
Referral	17	18	35	0.19
Restraint/Seclsuion/Rule 40	48	32	80	0.43
Restrictions	47	46	93	0.50
Serious Injury	1,286	1,303	2,589	13.80
Social Services	596	436	1,032	5.50
Special Review Board	27	51	78	0.42
Staff/Professional	119	134	253	1.35
Training	4	1	5	0.03
Transportation	27	17	44	0.23
Treatment Issues	165	178	343	1.83
Violations of Rule or Law	10	20	30	0.16
Total	**9,564**	**9,195**	**18,759**	**100.00**

Based Services providers were required to discontinue the programmatic use of aversive and deprivation procedures. After an 11 month transition period, the use of punitive practices and procedures, such as seclusion and restraint, was prohibited. Providers were also required to report to the OMHDD whenever restrictive or prohibited procedures, including emergency manual restraints, were used. These reports are called Behavior Intervention Reports (BIRFs). There were 2,071 BIRFs received in FY14 and 8,587 received in FY15. These BIRFs are reviewed by the Regional Ombudsman.

The Regional Ombudsman handled a total of 9,062 individual cases in this biennium.

Contacts by Type for Biennium

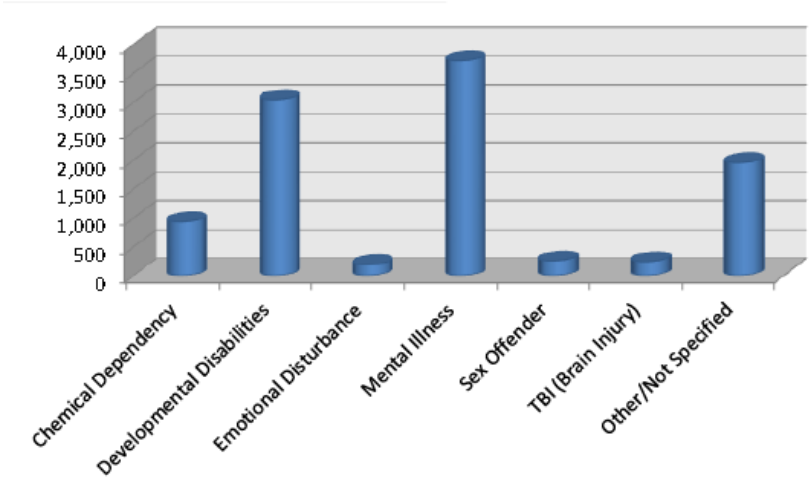


There were 4,530 in FY14 and 4,532 in FY15. These are broken down in the Contacts by Type chart and Contacts by Disability chart, both located on this page. Persons with a developmental disability or mental illness continue to have the largest numbers of contacts with the OMHDD.

The highest number of issues dealt with continue to be serious injuries, client rights, and medical issues. These cases can be a simple assist where information is given or an appropriate referral provided if it is an issue we cannot deal with. A client review is a case where more in-depth work is required. These are more time consuming for staff and involve document reviews, attending meetings or working with the treatment team to resolve the clients concerns.

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

Contacts by Disability for Biennium



The OMHDD has also seen an increase in contacts regarding chemical dependency.

The serious injury reports are also a large part of the regional staff work. Some serious injury reports are reviewed and closed, as they are clearly accidental and did not involve a major injury and the client received adequate medical attention. Most serious injury reports require the regional staff to contact the facility to gather more information on the injury and medical attention received. It may also involve questions regarding what steps were taken to avoid the injury or what steps will be taken in the future to avoid injuries. There are also times the regional staff may contact the appropriate licensing unit to investigate the issue for possible neglect or maltreatment.

The OMHDD also receives Child Maltreatment and Vulnerable Adults Investigative reports from the DHS Licensing Division, Office of Health Facility Complaints and the Department of Education. These reports are a priority and are reviewed by the Ombudsman, supervisor and the regional staff of the region the facility is located in. OMHDD staff review all reports and when there is a concern with the facility a case will be opened.

The OMHDD staff may also ask the investigating agency to reconsider their findings if we feel the findings did not meet statutory requirements. In FY14 there were 760 reports received. In FY15 there were 617 reports received. The majority of these came from the DHS Licensing Division. (The Abuse/Neglect/Exploitation numbers in the chart are different than these notifications).

As stated above, in FY14 the OMHDD started to receive BIRFs. The first year the OMHDD received 2,071 of these reports. In the second year, the number jumped to 8,587 for a total of 10,658 BIRFs for the biennium. These reports were required for the use of manual restraints, other prohibited or restricted procedures, and other identified circumstances. The BIRFs were reviewed by the regional staff assigned to the presenting region. These reports were also reviewed by administrative staff. Despite their best efforts, OMHDD staff were not always able to review each report due to the number of BIRFs received.

The OMHDD also received 651 Special Review Board hearing notices from DHS for individuals committed as mentally ill and dangerous, sexually dangerous person or sexual psychopathic personality. These were reviewed by the supervisor and two regional staff. (The numbers in the chart are different than these notifications.)

Civil Commitment Training and Resource Center

The Civil Commitment Training and Resource Center (CCTRC) is housed in the OMHDD. The CCTRC provides training on the commitment act and answers questions providers and counties may have related to civil commitment.

The CCTRC provides trainings to county human services staff, health care providers, court personnel, law enforcement and some attorneys. The CCRTC provided 15 training sessions in FY14 with 419 attendees. In FY15, 15 trainings were provided with 482 attendees. These trainings can be for two hours to four hours long depending on the information being requested.

The CCTRC is also involved in Crisis Intervention Training for law enforcement officers. The CCTRC covers the use of emergency hold orders so law enforcement officers know when their authority to apprehend an individual and transport to an examiner for evaluation can and cannot be used. In FY14 there were five presentations with 104 attendees. In FY15 there were three presentations with 53 attendees.

As mentioned, the CCTRC also receives calls from counties, health care providers and others regarding the civil commitment process. Many of these are technical calls regarding if or when a commitment can be pursued or rights of individuals in the commitment process.

The CCTRC receives a large number of these calls, especially from county social workers and clients receiving services.

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

Medical Review Unit

Total number of reported deaths for the this Biennium was 1,570.

This total of deaths compares with 1,373 deaths reported in the previous Biennium.

The Medical Review Unit (MRU) started the biennium with three staff members: the Medical Review Coordinator, a part time nurse reviewer, and an intermittent part time reviewer. The part -time nurse reviewer retired in March 2014, leaving the Medical Review Coordinator and half-time intermittent reviewer in place until the end of January 2015, when the intermittent reviewer was replaced with a full-time nurse reviewer.

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

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

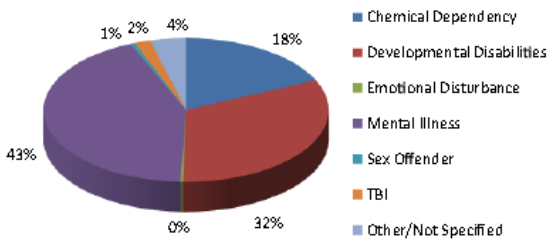
Death Reports

Both the Ombudsman and the Regional Ombudsman are notified of each death report when the report is received and again upon its closure.

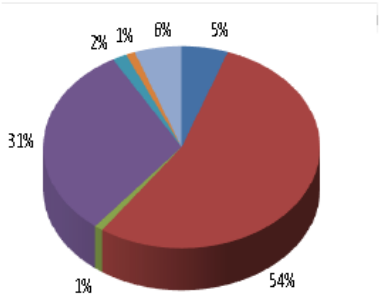
There were 718 deaths reported to the Medical Review Coordinator in FY14 and 852 deaths reported to the OMHDD in FY15 for a total of 1,570 deaths during this biennium.

These pie charts represent the Deaths and Serious Injuries reported to the OMHDD for this Biennium.

Deaths by Disability for Biennium



Serious Injuries by Disability for Biennium



Manner of Death	FY 2014	FY 2015	Biennium Total	Percentage (%)
Accident	73	95	168	11
Homicide	4	6	10	1
Natural	580	665	1,245	79
Suicide	47	55	102	6
Undetermined	14	31	45	3
Total	718	852	1,570	100

Approximately 50% of the deaths reported resulted in death reviews that were closed after initial review when the information provided was complete. Other death review cases are closed after the collection and review of additional records. Cases receiving further review are either closed after additional review by the MRU or are brought before the Medical Review Subcommittee for its review and for the formulation of recommendations to prevent the recurrence of similar deaths.

The Medical Review Subcommittee met six times during FY14 and five times during FY15 to review the deaths and serious injuries of clients that met its established guidelines. During FY14, the Medical Review Subcommittee reviewed and closed 32 death reviews. During FY15, the Medical Review Subcommittee reviewed and closed 18 death reviews.

While seeking opportunities to improve the care delivery system, the Medical Review Subcommittee looks not only at individual cases but also for patterns and trends. When it identifies patterns or trends, the Medical Review Subcommittee uses that opportunity to make recommendations focused on the care delivery system. These recommendations may come in the form of a letter to a provider or agency, a Medical Update, an Alert, a recommendation for a systemic review by the Ombudsman, or the development of educational tools such as our brochure entitled *Information for Individuals and Families about Suicide Prevention.*

The following Alert was created during the 2014/2015 biennium and remains available on the Ombudsman's website:

Metabolic Syndrome Update (PDF) - Summer 2014

Serious Injury Reports

There were 3,156 serious injuries reported in the 2,589 serious injury reports received during FY14/15 biennium. Of these, 749 serious injury reports were classified as "Other." Most of those reports were in stances of clients who either required medical evaluations for medical illnesses or conditions or for incidents of choking instances of clients who either required medical evaluations for medical illnesses or conditions or for incidents of choking.

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

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

Serious injury reviews are assigned upon intake to the Regional Ombudsman of the county in which the injury occurred. The Ombudsman, the Regional Ombudsman Supervisor, and the Medical Review Coordinator are notified of the closure of serious injury reviews.

The Medical Review Coordinator and the Medical Review Subcommittee remain available to the Regional Ombudsman staff for consultation on individual reviews.

Ombudsman's Website

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

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

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

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

Type of Serious Injury	FY 2014	FY 2015	Biennium Total	Percentage (%)
Burns (second or third degree)	76	58	134	4
Complications of Medical Treatment	22	19	41	1
Complications of Previous Injury	7	18	25	1
Dental Injuries (avulsion of teeth)	28	29	57	2
Dislocation	39	57	96	3
Eye Injuries	16	13	29	1
Fracture	725	769	1,494	47
Frostbite (second or third degree)	11	0	11	0
Head Injury (with loss of consiousness)	37	40	77	2
Heat Exhaustion/Sun Stroke	2	2	4	0
Ingestion of Poison or Harmful Substances	48	78	126	4
Internal Injuries	12	11	23	1
Laceration (muscle/tendon/nerve damage)	65	46	111	4
Multiple Fractures	49	76	125	4
Near Drowning	2	1	3	0
Other	388	361	746	24
Suicide Attempt	34	17	51	2
Total	**1,561**	**1,595**	**3,156**	**100**

(Continued from page 1)

(See Client Services Overview on page 2.)

In January 2014 the federal government released the Home and Community Based Services (HCBS) Rule. The Rule requires that people receiving publicly paid long-term services and supports must receive those supports in the most integrated setting and have full access to the benefits of community living. The rule has requirements for person-centered planning, service settings and opportunities for involvement in the community. This means that service planning must be led by the person receiving the services or supports and result in a plan that shows what is most important to him or her.

In addition to work done on the Jensen Settlement Agreement, the OMHDD developed a new case tracking and data collection system.

While the OMHDD worked with Minnesota's IT Department for assistance, the project development consumed much time and agency resources. OMHDD began using the new system July 1, 2013.

Despite the increased workload, the agency continued to provide a high level of service for OMHDD monitored clients, those who sought assistance and continued thorough reviews of client deaths. Minnesota residents can continue to rely on the services of the OMHDD.

Equal Opportunity Statement

The Office of Ombudsman does not discriminate on the basis of age, sex, race, color, creed, religion, national origin, marital status, or status with regard to public assistance, sexual orientation, membership in a local human rights commission, or disability in employment or the provision of services. This material can be given to you in different forms, such as large print, Braille, or on CD-ROM, if you call 1-651-757-1800 Voice or 711 TTY and make a request.

OMHDD Mission Statement

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

State of Minnesota

The Office of Ombudsman for Mental Health and Developmental Disabilities

2014/2015 Biennium Report to the Governor

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

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