UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

Patricia Welsch, et al.,	)	4-72 Civ. 451
	)	
Plaintiffs,	)	AMENDMENT TO COURT MONITOR'S FINDINGS OF FACT AND RECOMMENDATIONS PURSUANT TO PARAGRAPH 95(g)
	)	
-vs-	)	
	)	
Leonard W. Levine, et al.,	)	
	)	HEARTHSIDE HOMES COMPLIANCE PROCEEDING
Defendants.	)	

1. By letter dated January 24, 1986, plaintiffs requested that the January 22, 1986 Findings and Recommendations in the above-captioned matter be amended by deleting "and" at the end of recommendation 5a on page 198 and substituting "or".

2. The amendment is hereby granted. The two components of the recommendation -- 5a and 5b -- should have been phrased disjunctively. That was the intention. The review recommended by paragraph 5 is to cover two (albeit somewhat overlapping) subclasses:

-- class members receiving case management services from the St. Louis County Social Services Department;

-- all class members residing in residential facilities with a per diem of $45.00 or less throughout the state and regardless of whether or not they are receiving case management from St. Louis County.

3. I am taking this opportunity through the attached errata to correct several other errors which are of a minor nature.

February 5, 1986
Dated

Richard A. Cohen
Court Monitor

Attachment

cc. Judge Harry MacLaughlin
Leonard Levine
Deborah Huskins
Luther Granquist
Jeffrey Stephenson
John Clawson
Edward Skarnulis
Gerald Nord

ERRATA TO FINDINGS OF FACT AND RECOMMENDATIONS IN HEARTHSIDE, JANUARY 22, 1986

page 63 -- On the last line of the page, the word "home" should be substituted for "hone".

page 96 -- The last date referred to in paragraph 24 should be 8/31/84 and not 9/30/84, and the page reference to Ex. 101 which precedes it, should be to pp. 205-207 and not pp. 205-208.

page 141 -- Paragraph 22, line 5, should read "does not depict" and not "do not depict".

page 160 -- The sixth sentence in paragraph 2.20 reads: "It is the obligation to supply not only of Welsch, but because the structure and nature of the state-county system under CSSA, compels it." It should read: "Standards are necessary not only because of Welsch, but because the structure and nature of the state-county system under CSSA compels it."

See 2.13 at p. 184

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

Patricia Welsch, et al.,	)	COURT MONITOR'S FINDINGS OF FACT AND RECOMMENDATIONS PURSUANT TO PARAGRAPH 95(g)
Plaintiffs,	)	
-vs-	)	HEARTHSIDE HOMES COMPLIANCE PROCEEDING
Leonard W. Levine, et al.,	)	
Defendants.	)	No. 4-72 Civ. 451

PURSUANT to paragraph 95(g) of the Consent Decree, the following are findings of fact and recommendations* in the above-captioned proceeding together with conclusions which were necessary or incident thereto:

I. PROCEDURAL HISTORY; OVERVIEW

A. Procedural History

1. On May 30, 1984, a Notice of Initial Determination by Court Monitor Pursuant to Paragraph 95e was issued by Lyle Wray, Ph.D., the then Court Monitor, directed to the defendant Commissioner of the Department of Human Services (DHS), Leonard W. Levine.[1] Ex. 17, p. 55. The Notice of Initial Determination (hereinafter "the Notice") was based on, among other things, plaintiffs' initial report of October 31, 1983 relative to two class members' placements and programs at Hearthside Homes (Ex. 1) and responses to plaintiffs' report from St. Louis County and Department of Human Services' personnel. Ex. 17, pp. 58-59.

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* An index to these findings and recommendations is attached hereto at p. i.

2. The Notice found that serious questions had been raised by plaintiffs and substantially corroborated by the County and DHS in their responses as to whether:

-- the class members were being provided programs and a placement which appropriately met their individual needs;

-- the class members' programs at Hearthside met their needs as identified in the state hospital discharge plans;

-- there was an adequate number of trained staff at Hearthside;

-- appropriate care and treatment was being provided with regard to the administration of psychotropic medication; and,

-- whether the Commissioner had taken necessary steps to meet his responsibilities under paragraphs 1 and 24 of the Decree. Ex. 17, p. 59.

3. The Notice further provided that this was an initial determination of non-compliance and subject to change on the basis of evidence which may be presented in subsequent proceedings. Id. The Notice requested a formal response from the Commissioner by July 1, 1984. Id. at 59-60.

4. Dr. Wray resigned his position as Court Monitor effective May 31, 1984. The current Monitor, the undersigned herein, assumed the position on September 17, 1984.

5. A draft response, as opposed to a formal one as had been requested, was provided to plaintiffs' counsel in July 1984, apparently because the Monitor's position was vacant. Ex. 22.

Subsequently, a formal response on the merits of the Notice, dated October 5, 1984, was filed with the current Monitor, along with a letter dated October 9, 1984. The letter raised issues regarding the sufficiency of the Notice contending that it failed to adequately apprise the defendants of the basis of the Monitor's initial determination of non-compliance as it failed to articulate the Monitor's view of what was required by paragraph 24 of the Decree. Ex. 23, pp. 68-71.

6. In an October 24, 1984 letter and memorandum, plaintiffs responded to the Commissioner's position on the substantive and the procedural issues. Plaintiffs further requested, at that time, that the initial Notice be amended "to include a finding that the Commissioner has refused to provide persons acting under his direction and control with any elaboration of what the Department would consider to be an appropriate placement under paragraphs 24 and 26 of the Decree." Ex. 25, p. 82. While, as mentioned above, the defendants were requesting clarification from the Monitor of his view of what was required by paragraph 24, they objected to the amendment proposed by the plaintiffs.

7. The amendment was allowed, and defendants' initial and subsequently renewed objections to the adequacy of the Notice and to plaintiffs' proposed amendment were overruled. Exs. 26, 27, and 29. As the record reflects, plaintiffs' amendment hardly constituted what defendants' counsel characterized as a "ninth hour" change in the proceeding. First, plaintiffs' amendment was made just two weeks after defendants' formal response to the merits of the Notice and approximately two months before the

commencement of the hearing itself. Second, the issue of the Commissioner's obligation to articulate the requirements of paragraph 24 has been raised, implicitly, explicitly, and repeatedly, both by the previous Monitor and plaintiffs' counsel prior to the issuance of the Notice and even prior to emergence of the Hearthside case in 1983. See plaintiffs' proposed findings 3.3-3.7 and Ex. 13. A committee consisting of, among others, state hospital program directors, was assigned the responsibility by DHS to develop discharge procedures and standards. This action was apparently taken largely in response to plaintiffs' urgings for standards. See Ex. 84, p. 1. This committee made written recommendations in February 1984. Id. Third, the normally liberal policy and practice in favor of allowing amendments to pleadings is relevant and instructive. Indeed, the rationale for such a policy is particularly strong here given the posture of the case. While procedural protections are a two-way street and defendants along with plaintiffs are entitled to the safeguards in paragraphs 95 (e)-(g), the remedial and implementing nature of the Decree justifies and requires that all issues which naturally flow from or contribute to non-compliance be at least examined. The nature of such a remedial Decree dictates that issues not be artificially compartmentalized and put off for another day.

8. After the Notice was issued, efforts were made to resolve this matter prior to and after the hearings began, at times involving solely counsel, and on other occasions, in conference with the Monitor. None were successful. See Exs. 19 and 20, pp. 63-66; plaintiffs' proposed findings 1.6, 1.11, and

1.12. Other attempts were made prior to the issuance of the Notice in May 1984.

9. The evidentiary hearing pursuant to paragraph 95(g) was commenced in Duluth, Minnesota on December 20, 1984. At the outset of the hearing, Hearthside Homes, Inc., who had retained counsel, requested and was granted permission to participate at the hearing through examination of witnesses and preparation of memoranda. Tr. 12/20/84 (AM), p. 14. Testimony was taken from 15 fact or expert witnesses, several of whom were called both by plaintiffs and defendants during their respective presentations, over eight non-consecutive days in Duluth and St. Paul during a three-month period, ending on March 15, 1985.

10. The findings and recommendations herein are based on the complete evidentiary record of this case including the testimony, oral argument, and numerous exhibits introduced by the parties and the Court Monitor. (The latter under a notice pursuant to Minn. Stat. §14.60(2) -- see Court Monitor's Ex. D[2]; Tr. 3/6/85, pp. 4-7; written memoranda and proposed findings of the parties and Hearthside submitted after the hearing as well as a March 8, 1985 unannounced site visit by the Monitor to Hearthside in which he toured the facility and grounds and met the three class members. No records were reviewed on the visit. Tr. 3/15/85, pp. 10-11. Exs. 36-39, Dept. Exs. 12-15, and Court Monitor's Exs. P, Q, and R were submitted after the hearing to supplement the record, have been ruled on, and accepted into evidence.[3] The following other exhibits were introduced during the hearing but were not marked until after the hearing: Exs. 61-64, Court Monitor's Ex. O, and Dept. Ex. 11.

B. Overview of Hearthside and Three Class Members

1. Hearthside Homes, Inc. is a large residential facility with a capacity of 40 residents. It is in an attractive but remote setting on Lake Vermillion within the municipal limits of Tower, Minnesota, a town in the Iron Range in Northeast Minnesota. Tr. 12/20/84 (AM), pp. 29-30. Hearthside Homes actually consists of four separate residential buildings, plus a boathouse and a greenhouse, both of which are somewhat multi-purpose in character offering some arts and crafts, leisure time, and social activities. The residential buildings are as follows: the main building, which has a large living room, staff office, bedrooms for 10 male residents, and the only kitchen and dining area at Hearthside; another two-story building called an "apartment" where 14 female residents reside; the "log cabin", a very attractive and comfortable building for 3 to 4 residents; and the "Men's house" which houses 11 male residents. See Tr. 12/20/84 (AM), pp. 31-39.

2. The two male class members who are the focus of this case, Daniel, age 34 and Mark, age 38, both reside in the Men's house. They were provisionally discharged from Moose Lake State Hospital (hereinafter MLSH) to Hearthside on February 24, 1981 (Ex. 102, pp. 1-2) and on April 1, 1983 (Ex. 103, p. 3), respectively. While this proceeding was pending, a third class member, Delores, age 47, was discharged from MLSH to Hearthside on September 10, 1984. Ex. 101, p. 1. She resides in the women's "apartment." Their respective records show that Delores and Mark were subsequently fully discharged from MLSH; however, Mark's

records fail to document a full discharge for him. See plaintiffs' proposed findings 2.4.

3. It is undisputed that Hearthside has been licensed and certified since its inception under Federal ICF/MR regulations and specifically as a Class A Supervised Living Facility by the Minnesota Department of Health and under DPW (now DHS) Rule 34, Mn. Rules 9525.0210-.0430. See plaintiffs' proposed findings 2.2 and defendants' 3. It thus has been eligible for and continues to receive Federal Title XIX Medicaid funds together with the required state and county matches.

4. It is also agreed that each class member is the responsibility of St. Louis County and is entitled to receive case management services pursuant to Rule 185. This was the case before, during, and after the discharge process from MLSH. Each class member is also under the guardianship of the Commissioner. Ex. 113, second page; Ex. 115; Ex. 116.

C. Statement of Issues; Parties' Positions

1. Paragraph 24 requires that persons discharged from state institutions "shall be placed in community programs which appropriately meet their individual needs." The provision further provides that: "Placement shall be made in either a family home or a state licensed home, state licensed program, or state licensed facility . . . ."

2. As the Court previously ruled in Bruce L., the DHS Commissioner has the ultimate responsibility to see to it that the provisions of the Decree are carried out, which in that proceeding involved paragraph 26. Welsch v. Noot, No. 4-72 Civ.

451 (Memorandum Order July 14, 1982) at 4. Paragraph 26, which parallels and, as plaintiffs point out, may very well be subsumed by paragraph 24 (Memorandum, p. 10), imposes an "appropriateness" requirement to the day, special education, or vocational component of the community placements. It obviously follows that the ultimate burden for enforcement of paragraph 24 falls on the defendant Commissioner. Thus, the Notice in this matter, both appropriately and of necessity, addressed two issues -- (1) the adequacy of programming and staffing at Hearthside at the time of the class members' discharge from MLSH and thereafter; and (2) the Commissioner's obligation to assure that such programming and staffing were provided to the three class members at Hearthside in a manner which appropriately met their individual needs. To be more specific, the issues may be cast as follows:

a. Whether there was a reasonable assurance that Hearthside had the programmatic and staffing capability to appropriately meet the class members' individual needs at the time of their respective discharges from MLSH and thereafter; and whether the procedures in place and operating were (and are) adequate to assure that such a standard(s) would be met and maintained; and

b. Whether the Commissioner has taken all necessary actions and steps to assure:

(1) that an adequate discharge process existed to make it reasonably likely that the placements would appropriately meet the needs of these class members; and

(2) that Hearthside would maintain or achieve this standard.

c. Whether and how effectively and promptly the Commissioner responded to the alleged and then acknowledged inadequacies once he was specifically apprised of them.

3. The Court Monitor's Notice was sent to the Commissioner on May 30, 1984. The Notice relied on plaintiffs' October 17, 1983 visit to Hearthside (Ex. 1, p. 1); the findings from the visit which were compiled and forwarded to the Monitor and then to the Commissioner on October 31 and November 1, 1983, respectively (Id. and Ex. 3, p. 20); St. Louis County's responses and reports dated December 19, 1983; and a March 6, 1984 Memorandum from a DHS (or, as then known, Department of Public Welfare) Licensing Consultant to his Supervisor. The latter two documents substantially corroborated plaintiffs' claims.

4. As will be described with more specificity, the evidence presented at the hearing demonstrated substantial agreement between the parties concerning the problems at Hearthside, not only as they existed prior to the Notice, but well after. See, e.g., letter from Assistant Commissioner Sandberg to Ronald Abrahamson, Hearthside's Administrator, dated February 22, 1985, Ex. 59. Nevertheless, some of the testimony did reveal factual disputes, particularly over the extent of recent improvements and the potential for further improvements both at Hearthside and to other components of the service system on the county and state levels integral to the provision of services to class members.

5. Plaintiffs' position may be summarized as follows (see "Plaintiffs Proposals Regarding the Court Monitor's Recommendations . . .", April 17, 1985, pp. 1-3):

a. Hearthside did not in fact have the program or staffing capability to appropriately meet the individual needs of each class member at the time of their discharges. Nevertheless, because of the failings of the discharge process at the state hospital and at the county case management level, the discharges occurred, and were permitted without consideration given to a plan to promptly remedy the inadequacies at Hearthside.

b. That after placement, the needs of the class members continued to go unmet, and the protections and safeguards in the system, including case management and licensing, did not adequately operate to remedy the problems either before or after the matter was brought to the direct attention of county and state officials.

c. The Department, both before and then after it was put on notice, failed (1) to develop and/or enforce existing standards as to what constitutes an adequate individual habilitation plan and program and adequately trained staff to properly carry it out; and (2) to adequately address and remedy problems in the service system which directly affected the class members or Hearthside's ability to meet their needs, including inadequacies in county case management, the Department's own licensing, training, and technical assistance to Hearthside and county staff, and the problems created by the low rate of reimbursement to the facility itself.

6. The defendants' dispute with the Notice and plaintiffs is first and foremost a legal one.

a. Initially, they state that the term "appropriate" references federal constitutional standards.

b. They advance a second theory which assumes that the intent of the Decree was to, in effect, incorporate the status quo as it existed when the Decree was approved on September 15, 1980. See defendants' memorandum, pp. 26-27, 29, and 33. Defendants' witnesses stated that the process and standard at that time was whether the resident on the whole would be "better off" as a result of the community placement. They then testified that this was essentially the standard applied and met for the placement at Hearthside of each class member, and that Hearthside approximated the average level of quality of most community-based facilities in 1980. Id.

c. Alternatively, the defendants argue that even under state standards (e.g., Rule 185, Rule 34 Licensing Standards) or plaintiffs' standards, which were acknowledged by their witnesses to be very similar (defendants' proposed findings 198), that while deficiencies remain, there has been progress and with their assistance, more improvement can be expected, thus obviating the need for further Welsch intervention in the form of paragraph 95(g) recommendations.

d. With regard to the broader system issues, somewhat parallel positions are set forth. First, the defendants contend that the Decree does not require issuance of standards or any other system corrections because it merely incorporated what existed in 1980. They arrive at this conclusion because of what they contend to be a lack of specific provisions requiring DHS to "reform" the community system. Id. at 29-30, 36-44. They then indicate that the evidence shows that the mechanisms and safe-

guards designed to ensure adequate programming in the community, e.g., the discharge process, case management, licensing, are working as well now as they were in 1980, and indeed better, and this was and is so with regard to the initial and continued placements of the class members at Hearthside.

e. Lastly, defendants argue that although not required by the Decree DHS has taken a number of systemwide actions, e.g., the institution of the Waiver program, creation of Regional Service Specialists, issuance of instructional bulletins, to improve the system throughout the state. Id. at 42-44.

7. What is apparent in comparing the positions of the plaintiffs and defendants is that, despite seven days of testimony, the primary differences involve legal questions. This is not to say that there are no factual differences concerning, for example, the degree to which Hearthside or St. Louis County case management has improved its services to the three class members. Nonetheless, defendants acknowledge continuing and substantial deficiencies at Hearthside measured against not only their own state licensing standards (Ex. 59), but against the similar standards proposed by plaintiffs. Defendants' proposed findings, p. 5. Thus, given that much of the case and subsequent factual analyses turns on the resolution of the requirements of paragraph 24, this issue will be examined first.

II. REQUIREMENTS OF THE CONSENT DECREE

A. Introduction

1. A careful analysis of the positions of the parties shows that at least facially there is remarkable agreement as to the components needed for a placement to appropriately meet the individual needs of its residents. That a placement must provide for health, safety, environmental and programmatic needs of its residents is undisputed. The dispute here concerns primarily (although not exclusively) the programmatic factors of what is needed in the development and implementation of an individual habilitation plan (hereinafter IHP) to ensure an adequate placement under paragraph 24.

2. Whether an IHP is necessary is not at issue. This could hardly be otherwise, given the explicit requirement for an IHP in paragraph 22(c) of the Decree and the central role it plays in services to persons with mental retardation. See Part II(C)(3) infra. To ensure that class members' individual needs are appropriately met, plaintiffs argue that adherence to professional standards governing IHP's is needed. Defendants contend that the placement should be viewed as a whole with the IHP as one part of it. The determination should then focus on whether the placement will result (or has resulted) in an improved situation for the class member vis a vis his/her previous status.

3. Regardless of the standard used, it should be pointed out that the primary issue in this proceeding -- the adequacy of the IHP process in a residential placement -- is indeed only one element, albeit an essential one, in an overall community placement. This is so in at least three related ways. First,

other provisions of the Decree, and most notably paragraph 26, address the requirements of day, education, and/or vocational services in a community placement. As discussed infra, especially with respect to severely handicapped individuals who make up the vast majority of the class, there generally is (or should be) linkage and coordination between services provided in the residence and at the day, education/vocational work sites. Each of the three class members attends a developmental achievement center (DAC); however, their day program services will only be examined in an incidental way as it relates to their residential program. There are, of course, other services that are provided outside of both the residence and day program that may be necessary for a successful community placement, such as medical or dental services, and this is contemplated by paragraph 22(d) which states that: "The scope of supportive services . . . be provided to meet the resident's needs as defined in the assessment made pursuant to paragraph 21 . . . ."

4. Second, paragraph 21 provides the beginning point for discharge planning by requiring yearly assessments of each individual resident's "actual needs" for the purposes of determining the type of placement he/she will need when discharged as well as the overall scope of services. Under paragraph 22, the needs assessment is then used in fashioning the discharge plan for use in the community placement. Paragraph 22 states:

> [P]rior to a resident's discharge from an institution, the county social worker, in cooperation with the resident, the parents or guardian, community service providers, and the interdisciplinary team shall formulate a discharge

plan which includes, but is not limited to, the following provisions:

a. The type of residential setting in which the resident shall be placed;

b. The type of developmental or work programs (work activity, sheltered workshop, or competitive employment) which will be provided to the resident;

c. An individual habilitation plan consistent with Department of Public Welfare Rule 185 to be implemented when the resident is placed in the community placement;

d. The scope of supportive services which shall be provided to meet the resident's needs as defined in the assessment made pursuant to paragraph 21 . . . .

Thus, the discharge plan provides the initial guarantee and acts as a kind of umbrella for all the services that are to be provided upon discharge, including residential. See Bruce L., pp. 3-4.

5. Third, apart from the primary sites of the services (e.g., residential or day program), in planning for or providing for a person's actual individual needs the elements looked at and the functions performed encompass more than the development and provision of a habilitation program. The very purpose and function of habilitation to this group of individuals makes it an overriding feature of service delivery. See Part II(C)(3). However, as with all people, they have other needs separate from or only indirectly related to what are traditionally classified as habilitation needs. These needs, of course, include shelter, clothing, food, and basic medical care including appropriate administration of medication, protection from abuse, and environmental concerns.[4] See also Ex. 119 with regard to broader issues

raised in the Hawthorne House compliance hearing. However, because of the central importance of the IHP in the service system and in providing for all the needs of class members, the requirements of an IHP may be discretely examined.

6. As this Court stated in Bruce L. and reiterated recently Welsch v. Levine, No. 4-72 Civ. 451 (TAP proceeding) (Memorandum and Order, October 17, 1985), p. 3, and as both parties acknowledge, a consent decree is to be viewed as a written contract and the customary aids of construction apply. The intent of the parties must be ascertained within the four corners of the decree, "and not by reference to what might satisfy the purposes of one of the parties to it." United States v. Armour & Co., 402 U.S. 673, 682 (1971); Welsch v. Levine, (TAP proceeding), supra at 3. In construing the provisions, but without making "a fortress out of a dictionary" (Cabell v. Markham, 148 F.2d 737, 739 (2d Cir.) (L. Hand, J.), aff'd, 326 U.S. 404 (1945)), language should be interpreted in accordance with the generally prevailing meaning unless the parties manifest a different intention or the words are technical. United States v. ITT Continental Baking, 420 U.S. 223, 238 (1975). As was also stated in ITT Continental, p. 238, other aids of construction may also be used when appropriate:

> Since a consent decree or order is to be construed for enforcement purposes basically as a contract, reliance upon certain aids to construction is proper, as with any other contract. Such aids include the circumstances surrounding the formation of the consent order, any technical meaning words used may have had to the parties, and any other documents expressly incorporated in the decree. Such reliance does not in any way depart from the 'four corners' rule of Armour.

Where ambiguity or confusion may exist over the terms of the decree, courts are not constrained and indeed are required to interpret or clarify such ambiguity so as to ensure that the object and purpose for which the decree was entered into is carried out. Monsanto Co. v. Ruckelshaus, 753 F.2d 649, 653 (8th Cir. 1985); Pasadena City Board of Education v. Spangler, 427 U.S. 424, 438 (1976); and Brown v. Neeb, 644 F.2d 551, 559-60.

B. Defendants' Argument

1. Defendants offer several grounds for their position that paragraph 24 imposes, in effect, a "better off" standard (defendants' memorandum, p. 33) by which to judge whether a placement will (or is) appropriately meet the needs of class members.

2. First, they contend that there is lack of specificity about the community placement in the Decree, and this demonstrates that the parties did not intend to change the status quo either with regard to the standard used to judge the adequacy of a placement (defendants' memorandum, pp. 22-34) or in the measures DHS was required to take to improve the system. Id. at 36-45. On pages 22-23, they state:

> It is evident from the brevity of the reference and from the use of a term such as 'appropriate' in drafting the Decree that the standards to be applied in determining 'appropriateness' of community placements received little attention. The Consent Decree is explicit where the defendants were required to change the status quo. As it is not explicit in paragraph 24, the parties apparently contemplated no change. Therefore, none can be required now.

3. Testimony was offered as to the practices and standards supposedly in effect in 1980. In short, it was described

as follows: state hospital team members weighed a number of factors and then made a professional judgment as to whether, on the whole, the client would be better off "regardless of whether the facility ha[d] weaknesses in programming . . . ." Id. at 33.

4. Second, as a corollary to their first point, defendants argue that only the legal minima[5] is required relying on case precedent in other jurisdictions, including most notably, Youngberg v. Romeo, 457 U.S. 307 (1982). Defendants' memorandum, pp. 26-28. The implications of Bruce L. are discussed below. Cases cited, including Romeo, are inapposite as they did not involve interpretations of consent decrees, let alone this one.[6]

5. With regard to the status quo argument, first, it should be noted that their primary, if not exclusive, manner of proof as to the 1980 discharge practices and standards came through witnesses' recollections. Defendants' memorandum, pp. 22-24.

6. This is found not to be very probative on what the parties through counsel intended when they agreed to assure that each person discharged between 1980 and 1987 would be placed in settings which met their individual needs. This is particularly so when the witnesses relied on were all individuals who had an interest in the Hearthside proceeding (e.g., staff), or whose actions were being called into question, and who then testified that discharge processes for the three class members at Hearthside as well as their placements met this 1980 standard. Id. at 24-26. Moreover, as will be discussed in Part III(A) below, their testimony was not always substantiated with respect to how the class members were progressing.

7. Thus, even if the status quo/better off standard was relevant, given its inherently amorphous nature, to utilize testimonial recollections from witnesses privy not to the negotiations over the Decree, but ironically having an interest in the outcome of a compliance proceeding under the Decree, seems highly problematic and not in accord with rules permitting the use of construction aids.

8. Second, a different case might exist if the Decree implicitly or explicitly referenced a written standard which described the status quo. Indeed, if the Decree is silent, as the defendants contend, its silence cuts directly against, not in favor of, their argument.

9. Third, as discussed in the next section, there is no paucity of provisions which describe affirmatively what is required. Fourth, the very provisions of the Decree, including particularly paragraph 24, belie defendants' own interpretation. Paragraph 24 requires discharge and placement into community programs which appropriately meet the individual needs of each class member. Webster's New Collegiate Dictionary defines appropriate as "especially suitable or compatible: FITTING". Id. at 56 (1977). While neither the word nor the requirement is especially precise or specific, it clearly sets out an absolute standard, and read particularly in conjunction with paragraphs 21 and 22, a placement deemed "better off" is, by definition, hardly supportable. The short and perhaps best answer is had the parties intended this standard they could have stated it.

10. As discussed in detail in Part V(B), other provisions of the Decree, as well as contemporaneous circumstances which are

documented or memorialized, also belie the contention that all that was intended was to assure that class members were better off.

11. By way of one example, paragraphs 37 and 39 require that the numbers of staff at the state hospitals be maintained even as the population of class members is reduced until "the desired staff to resident ratios are achieved at each state hospital." Welsch v. Noot, No. 4-72 Civ. 451 (Memorandum Order March 23, 1982), p. 3. To conclude at that point in time that a setting which would result in a placement better than life in a ward at a state hospital, acknowledged implicitly to be inadequate, in short, defies the very language used in paragraph 24, as well as the purpose of the Decree. United States v. Swift & Co., 286 U.S. 106 (1932).

12. Based also on their paucity of provision argument, defendants attempt to limit the Decree in one other way. They imply that whatever the standard of "appropriateness", the duty to assure it under the Decree exists only for the first 60 days of the placement, terminating when the county case manager completes the sixty-day evaluation under paragraph 22(c). Defendants' memorandum, p. 37. The basis for this proposition is belied by the subsequent discussion in their memorandum in which they cite paragraphs 34 and 35 on licensing. The language in paragraph 22(c) which calls for an IHP consistent with Rule 185 to be implemented upon placement (and not for just 60 days), also undercuts defendants' argument. Finally, defendants' interpretation which, in effect, would provide for appropriate provision of

services only during institutionalization and 60 days thereafter, only to then afford a class member less protection thereafter, constitutes an unreasonable interpretation of the letter and spirit of the Decree and would undermine its purpose and policies. United States v. Swift & Co., supra, § 203(a) Restatement of Contracts 2d (1981).

C. Findings and Conclusions With Respect to the Development and Implementation of Individual Habilitation Plans, Generally

1. While the plain language of paragraph 24 demonstrates that more was intended than that class members be "better off", that does not dispose of the question of what is required and whether or not it supports or subsumes plaintiffs' explicit interpretation or that implied by the original Notice.

2. Plaintiffs state "it cannot in good faith be disputed that a community program which appropriately meets class members' individual needs is one in which the class members are provided an individual habilitation plan which is especially suited to their individual needs." Plaintiffs' memorandum, p. 8.

3. The question posed is whether paragraph 24 requires the development and implementation of an IHP; and if so, what are the essential components of the plan and process?

4. Again, not only does agreement exist as to the necessity of an IHP, but save for minor shades of disagreement, there is general accord on the components of an adequate IHP as well. As to the general requirement for an IHP, plaintiffs rely primarily on the language of paragraph 24, several allied provisions of the Decree, and Bruce L. (plaintiffs' memorandum, pp. 5-8). They

turned to expert witnesses with respect to the specific components which are needed. Id. at 8.

5. It is in fact concluded based on the Decree and the record (including but not limited to the expert testimony, much of which came from DHS employees), that an IHP must be properly developed and implemented to assure that class members' individual needs are appropriately met. Similarly, it is concluded that, with minor modification, the components of an IHP proposed by plaintiffs[7] are necessary to ensure that the individual needs of class members are appropriately met. These are discussed in detail in Section (D) below, and together with the general finding that follows, are summarized in Appendix A.

6. In order for a placement to appropriately meet individual needs of class members, an IHP must be ensured for each individual which has been developed by an appropriately constituted interdisciplinary team based upon the class member's assessed needs and strengths, and implemented in a comprehensive and integrated manner in and across the residential and day programs and other appropriate, natural, functional, and/or community environments and settings. It must be monitored through collection of objective data and evaluated regularly to determine whether the program is effective, and should be continued, terminated or modified as necessary in light of that evaluation. The selection of goals, objectives, and teaching implementation strategies should be based on the integration of pertinent evaluations, input, and views of the interdisciplinary team members and any other relevant contributors.

7. While general agreement exists, because defendants' construction of the Decree does (or could) limit or dilute the enforcement of or adherence to the requirements of an IHP in the placements of class members, the bases for the conclusions and findings herein will be set forth. Examined first will be the general need for a well conceived and effectively executed IHP as required by (1) the provisions of the Decree and State/Federal standards incorporated or referenced therein; (2) expert testimony and professional standards and literature; and (3) the purpose and function of habilitation as it applies to class members. The specific components of the IHP process will then be addressed. See Subsection D below.

1. Provisions of the Decree; State and Federal Standards

1.1 In Bruce L., a class member's community DAC program was cut back from five to three days without regard to his needs. The Court determined that the "appropriateness" requirement of paragraph 26 was violated both because the process for determining Bruce's needs had been subverted and because of the harm he might suffer. Bruce L. at 6.

1.2 The process for determining Bruce's needs was prescribed by paragraph 22 and, as discussed in more detail below, includes the development of a discharge plan and an IHP by the class member's interdisciplinary team. Id. at 4-5. Moreover, as the Court held, based on paragraphs 21 and 22, the discharge plan or IHP could only be developed and subsequently modified based on the class member's needs and through the inter-

disciplinary team process. Reducing Bruce's day program based on budgetary concerns and not on his needs violated the Decree.

1.3 Bruce L. not only underscores the importance and requirement of the class member's team in formulating his plan and program, but also demonstrates the inextricable link between the interdisciplinary team process and the determination and fulfillment of the class member's individual needs. As found in Bruce L. and discussed below this is implicit, if not explicit, when paragraph 24 is read in conjunction with paragraphs 21 and 22. Id. at 3.

1.4 Also instructive is the substantive factors the Monitor and subsequently the Court examined in determining the need and appropriateness of five days versus three days. As the testimony showed, the reduction in DAC services would result in a reduction of skills that the class member had learned since his discharge from the state hospital and jeopardize his development and continued progress "toward the realization of his potential." Id. at 6. There was also testimony that a cutback in DAC services would curtail his interaction with other people resulting in regression in his socialization skills. This the Court ruled would be inconsistent with the appropriateness requirement of paragraph 26 as well as the discharge plan required by paragraph 22.

1.5 The allied provisions of the Decree were of great benefit to the Court in arriving at its holding in Bruce L. In light of the slightly different issues presented in this case, these provisions will be examined in light of the instant facts, beginning with the assessment and discharge process and evaluation.

1.6 Both sections require assessments of a class member's needs. Paragraph 21 makes explicit provision for a yearly assessment while the class member is a resident at the institution, in order "to identify the type of community placement . . . and the scope of services the resident will need when discharged to a community placement". Such assessment is to be based on the "actual needs of the resident rather than in terms of services presently available." The actual discharge and discharge process under paragraph 22 also requires that the services and placement be based on the assessed needs of the class member. Subsection d requires that "supportive services . . . be provided to meet the resident's needs as defined" by the paragraph 21 assessment. A Rule 185 IHP which is incorporated by paragraph 22(c) is the overall plan governing all aspects of the placement and it must be based on a comprehensive assessment of client needs. See 1.27 and D(1.1) below.

1.7 Paragraph 21 very explicitly provides that the yearly assessments of the client's actual needs are to be used by the Commissioner "in planning for and implementing the reduction in institution population required by this Decree" as well as "in developing plans for new residential and non-residential community based services." As is discussed in Part V(B), it was recognized by the Department when it signed the Decree that new and more sophisticated housing programs would be necessary not only because of the increased quantitative demands the population reduction requirements of the Decree placed on the system, but because the actual needs of the residents expected to be placed

were becoming increasingly complex, thus requiring qualitative enhancements and additions to the "status quo."

1.8 Second, the discharge plan, as stated above, in addition to specifying the type of residential, day, and supportive services that the client shall receive, also has to have "[a]n individual habilitation plan consistent with Department of Public Welfare Rule 185 to be implemented when the resident is placed in the community placement . . . ." Paragraph 22(c). The Rule 185 version introduced by the defendants (Dept. Ex. 4) and in effect when the Decree was signed, defines individual program plan[8] as follows:

> A detailed plan of the service provider setting forth both short-term and long-term goals with detailed methods for achieving movement toward the individual service plan of the local social service agency (Rule 34 standards and ICF/MR-regulations govern this in specific detail.)

Dept. Ex. 4, 12 MCAR Section 2.185, p. 346.

1.9 The implications of the references to the individual service plan and Rules 34 and ICF/MR regulations are discussed in more detail below. The reference or reliance on state standards is not limited to this provision, but is contained elsewhere in the Decree, e.g., paragraphs 24, 34, 35, and 63.

1.10 Third, within 60 days after discharge, the county social worker and, if requested, an appropriate member of the state hospital discharge team, must visit the community placement "to assess whether [the resident] is being provided the programs and services required by the discharge plan." Paragraph 22(e). The social worker then provides "a written assessment of

the appropriateness of the program and services being provided." Id. (emphasis added).

1.11 The above requirements constitute the process which is to result in a paragraph 24 placement; to wit, one which will appropriately meet the individual needs of the class members. The discharge process is not one, as stated above, which can be read to permit or sanction a placement which is merely better off on balance than a class member's previously institutionalized status. Rather, it must be arranged or developed based on the actual needs of the class member. (Bruce L., pp. 3-4), and include the development and implementation of an IHP (consistent with state and federal standards).

1.12 The language in paragraphs 21, 22, and 24 clearly indicates that all needs must be identified and met. By definition, it does not allow for a potentially very dangerous practice of allowing leeway in some areas as long as the placement as a whole seems to be an improvement. One thing is clear: the habilitative aspect of the placement is not secondary. In fact, these provisions evince a particular concern that the habilitative needs of class members be met. To be sure, the all-encompassing mandate of paragraph 24 requires that all factors that make up an adequate service array be addressed.

1.13 There is no question that the parties wanted to make sure that the habilitation requirements of a placement were ensured. This is perhaps consistent with the tenor of the suit from the outset (see Welsch v. Likins, 373 F.Supp. 487, 494-497 (1974)), as well as the Decree as a whole, including the institutional provisions, e.g., paragraphs 60 and 63.

1.14 Other community provisions of the Decree, whether viewed in pari materia, or somewhat independently, also demonstrate a particular concern of the parties toward the habilitative and program aspects of a community placement.

1.15 Paragraph 26 underscores the parties' intent that habilitation programming be provided by requiring "appropriate educational, developmental, or work programs" as part of a community placement.

1.16 As has been seen, two of the paragraphs which address the assessment and discharge process for individual class members, paragraphs 21 and 22, rely heavily on the interdisciplinary process and focus on habilitation. Similarly, paragraphs 28-33, "Technical Assistance", and 34-35, "Licensors", emphasize the programmatic aspects of community placement. These provisions are two of the primary mechanisms in the Decree aimed at enhancing the capability of the community service system (and in the case of licensing, its own capability as well) in providing or ensuring that the needs of class members will be met. A number of measures are delineated toward this end.

a. Licensors are to receive "[o]n-going training . . . by experts in programming . . . in the following areas: program planning for mentally retarded persons, behavior management, communication programs, and the needs of physically handicapped persons. Paragraph 34 (emphasis added). This section further provides:

> When conducting a licensing review to assess whether appropriate programs of habilitation are actually being provided, licensors shall directly observe program implementation, conduct interviews,

> review records and documents, and use appropriate checklists in their assessments.

In the original July 12, 1980 Memorandum of Understanding between the parties, this section called for training in the identical areas; however, the function of the training was "to enable them [licensors] to determine community settings are providing appropriate care . . . ." Id. at 13. This phrase and term was dropped, and as noted above, an additional sentence was added which spoke in terms of "appropriate programs of habilitation".

b. Technical assistance staff are to:

> Assist county boards and community mental health boards, as applicable, in (1) identifying the needs of their mentally retarded persons, (2) developing service plans based on the needs of the mentally retarded persons, (3) developing appropriate programs and services, (4) monitoring and evaluating service adequacy and effectiveness.

Paragraph 33(g).

c. Paragraph 33(d) provides that technical assistance staff are to:

> Assist providers in planning for the development of individual habilitation plans, with special emphasis on assisting in the development of programs for persons who are physically handicapped or who present severe behavior problems.

Emphasis added.

1.17 As mentioned above, the parties recognized that class members placed in the community would have increasingly more complex needs than their predecessors, and in a planning document developed at or around the time the Decree was negotiated, the Department outlined strategies to deal with this fact. See Six Year Plan for the Mentally Retarded, August 1980, Appendix B, and Part V(B) infra.

1.18 It appears that the provision for technical assistance staff was taken from the Department's plan to assist in addressing the community's ability to provide for the habilitation needs of this increasingly needy population, to wit the Welsch class. Appendix B, p. 25.

1.19 As paragraph 33(d) implies (as well as paragraphs 13 and 60), within the class as a whole there are subgroups of persons who present even more challenging needs by virtue of their physical handicaps or severe behavior problems. That these persons were not to be excluded from community placement, is clear from paragraph 13.

1.20 Whether or not out of recognition of the need to improve the service system's (institutional and community) capability to address the particularly challenging needs of this group (see Appendix B, pp. 16 and 18) the parties agreed to special provisions in the Decree, again, reflecting an apparent intent to assure appropriate habilitation.

1.21 As mentioned above, the technical assistance and licensing provisions of the Decree, recognized that additional training for and assistance to community providers and the licensors themselves was needed relative to the needs of severely physically or behaviorally handicapped class members. Paragraphs 33(d) and 34. Ongoing in-service training is to be provided for state hospital staff relative to serving the needs of severely handicapped particularly (albeit not exclusively) in the habilitative or program domain. Paragraph 60 states:

> In-service training programs at the state institutions shall include increased emphasis on the proper care of physically handicapped persons

> (with particular emphasis on their positioning needs), proper implementation of behavior management programs, effective training for severely and profoundly retarded persons in communication skills, and training with regard to the services provided mentally retarded persons by residential and non-residential community service providers . . . .

1.22 Paragraph 18(4), in recognition of the low incidence and special needs of severely handicapped children in the class, calls for consideration to be given to the location or development of multi-county "specialized regional community service[s]."

1.23 As in Bruce L., the allied provisions of the Decree are helpful in clarifying or confirming the intent of a single provision. They clearly support the view that the parties not only wanted a properly developed and implemented IHP to be included as part of the placement, but it was of paramount importance to them in assuring that the needs of increasingly handicapped individuals would be met in the community.

1.24 As mentioned above, the Decree references government standards,[9] e.g., paragraphs 22(c), 24, 35, and 63.

1.25 Paragraph 22(c) requires the development and implementation of an IHP consistent with Rule 185. While it is not a blanket incorporation, the reference is obviously of great assistance in determining what, at a minimum, may be required in an IHP in a community placement.

1.26 The version of Rule 185 in effect when the Decree was executed which the defendants argue the parties are bound by defines an IHP (or IPP) as a "detailed plan of the service provider setting forth both short-term and long-term

goals with detailed methods for achieving movement toward the individual service plan of the local service agency . . . .", and then refers to "Rule 34 standards and ICF/MR regulations [which] govern this in specific detail."[10] Dept. Ex. 4, 12 MCAR § 2.185, p. 346 (emphasis added).

1.27 The requirements in the previous or current version of Rule 185, as well as in Rule 34 and the ICF/MR regulations, support the findings herein with respect to the necessary components of an IHP, supra. The requirements of these rules and standards are generally set out below, but are discussed with more specificity in Part II(D), infra. The 1980 version of Rule 185 further defines an ISP as "[a]n analysis . . . for services needed by the client, including identification of the type of residential placement, and the general type of program required by the client to meet the assessed needs within a specified period of time." Dept. Ex. 4, pp. 345-346. The ISP must also be designed to enable the person "to acquire new and progressively difficult skills . . . [and] it must be based on a comprehensive assessment of needs, and annual evaluations to determine the appropriateness and effectiveness of the individual service plan." Id. at 346. The components of the assessment are further described at pp. 347-348.

1.28 As the 1980 version of Rule 185 suggests, Rule 34 and the federal ICF/MR regulations do provide substantially more specificity as to the requirements of an IHP. While it does not appear that the parties intended through paragraphs 22(c) and/or 24 that Rules 185 and 34 or the ICF/MR regulations were to be the sole or complete source of authority for determining the

adequacy of an IHP in a community placement[11], the language in paragraph 22(c) coupled with the heavy reliance or reference in other sections of the Decree entitles such standards to great weight.[12] The fact that Hearthside is a Rule 34 licensed and ICF/MR certified and funded program also make it appropriate to examine these standards to help determine, at a minimum, what is required to appropriately meet class members' individual needs.

1.29 The ICF/MR program provides for federal and state (and, in Minnesota, some county) reimbursement for residential and habilitative services for persons with mental retardation. 42 U.S.C. § 13.96 (a)(1)(5), Cleburne v. Cleburne Living Center, 87 L. Ed.2d 313, 317, note 2 (1985). Federal regulations for the ICF/MR program were first published in 1974. See 39 Fed. Reg. 2220, January 17, 1974 and codified at 45 CFR 249.10 (d)(1)(V). Since then, they have been revised and redesignated and are set forth in 42 CFR Part 442, Subpart G (1981).

1.30 The specific components of the IHP process as dictated by ICF/MR standards as well as other authorities and sources, are discussed in detail in the next section (Part II(D)); however, the following, in summary form, are the major ICF/MR standards relative to IHP development and implementation[13]:

(a) Interdisciplinary assessment of the resident to determine:

-- his/her current and future needs;

-- potential for his/her growth and development and movement to a less restrictive, more independent environment;

-- long and short-term goals and objectives; and

-- specific services and teaching/habilitation methods necessary to assist the resident in achieving the said goals and objectives.

§§ 435.1009(c) and (d), 442.445 and 456 and 463 and Interpretive Guidelines pursuant thereto, Appendix D, pp. 419-421, 493, 502, and 507.

(b) The development, implementation, monitoring, and review of the individual plan and program by and through the interdisciplinary process and team, and based on the above comprehensive interdisciplinary assessment. Id.

(c) The specific inclusion of the following components in the individual plan and program:

-- Measurable goals and objectives (the latter stated in behavioral terms) based on resident needs and without regard to availability of services. Id., 42 CFR 442.418 (b)(2)(i), Appendix D, p. 464.

-- In order to accomplish the objectives, a specification of the services to be provided, by whom, by what date, and in what environments, as well as specific teaching strategies to be employed. Id., 42 CFR 442.418 (b)(2), 442.434 and Interpretive Guidelines pursuant thereto, Appendix D, pp. 464, 482.

-- The plan should provide for methods to record and evaluate resident progress on an ongoing basis as well as monthly by the interdisciplinary team.

§§ 435.1009, 442.434, 442.456, 442.463, and 442.499 and Interpretive Guidelines pursuant thereto, Appendix D, pp. 419-421, 482, 502, 507, 553.

-- To assure proper implementation and monitoring and that residents otherwise receive "active treatment", a sufficient number of directly employed or consultant professional staff as well as direct care/paraprofessional staff. 42 CFR 435.1009 (c)(3)(e), 442.431-433, 442.464, Appendix D, pp. 419-421, 478-481, 509, Resource Manual for Surveyors and Reviewers, p. 120; see also 442.454-456, 474-481, 486-498, and Interpretive Guidelines, pp. 502, 520-531, 537-552.

1.31 The active treatment provision and the components thereof, cited above, are at the heart of the ICF/MR program and habilitation. They are reflective of both current professional practice and the rationale that underlies provision of services to mentally retarded persons. As stated in the introduction to the 1977 Interpretive Guidelines (Appendix C):

> Active treatment means an aggressive and organized effort to fulfill each resident's fullest functional capacity. It requires an integrated individually-tailored program of services directed toward achieving measurable behavioral objectives. It requires an environment approximating as closely as possible the patterns and conditions of everyday life in mainstream society. It has as its goal the development of those skills, habits and attitudes essential to adapting to contemporary everyday life in the community.

1.32 Rule 34 has as its purpose the establishment of minimum standards for residential programs and services for

persons with mental retardation, and the protection of the human right to a normal existence through the development and "enforcement of minimum requirements for the operation of residential programs." Ex. 86, p. 7308.

1.33 As with Rule 185 and the ICF/MR regulations, Rule 34 requires comprehensive interdisciplinary assessments relating to behavior, education, self-care, economic skills, language and communication, vocational skills, health, medication, motor impairments, vision, hearing, dietary, and psychological. Id. at 7315-7316.

1.34 An interdisciplinary team composed of residential and daytime program staff is to design an "individualized program and treatment plan for each resident", which must be implemented. Id. at 7316.

1.35 Subsequent amendments to Rule 185 have not abrogated the standards for IHP development in the 1980 versions, although the specific references to Rule 34/ICF/MR regulations no longer appear. The October 1984 version (Ex. 70) provides in part:

> The interdisciplinary team shall develop an individual habilitation plan that integrates the services provided by all providers and subcontractors to the person with mental retardation and ensures that the services provided and the methods used by each provider and subcontractor are coordinated and compatible with those of every other provider and subcontractor to achieve the overall results of the individual service plan.

Ex. 70, p. 19 (emphasis added). The individual service plan itself must be based on a comprehensive individual assessment and must state, among other things, long-range and annual goals and

the specific services and methods that will be used to achieve the goals. It must have as its purpose increased independence in and interaction with the community, etc. Id. at pp. 10-11, 13-14. See 9525.0065, 0085. The IHP must include:

> A. short-term objectives designed to result in the achievement of the annual goals of the individual service plan;
>
> B. the specific method of providing the service that is expected to result in the achievement of the short-term objectives of the individual habilitation plan;
>
> C. the name of the provider's employee responsible for ensuring that services are implemented as set forth in the individual habilitation plan and that the services result in achievement of the short-term objectives;
>
> D. the measurable behavioral criteria that will be used to determine whether the services have resulted in achievement of the short-term objectives;
>
> E. the frequency with which service will be provided;
>
> F. the starting date and completion date for each short-term objective.

Id. at 9525.0095, subp. 9.

1.36 In sum, it may be concluded that provisions of the Decree indicate that in ensuring that community placements appropriately meet the individual needs of class members, the parties were preeminently concerned with the adequate development and implementation of an IHP for each class member upon and after discharge into the community. This is evident in at least two ways: first, explicitly from the requirements of interdisciplinary assessment and discharge processes outlined in paragraphs 21 and 22, and the reference (in 22(c)) to Rule 185 (and indirectly to Rule 34 and the ICF/MR regulations); and, second, from the

provisions of paragraph 26 as well as other community sections which have as an important or primary concern the provision and/or enhancement of habilitation and IHP's specifically.

2. Testimony, Professional Literature, and Standards

2.1 Plaintiffs rely primarily on testimony of professionals in the field to prove what components are essential to the IHP process. This is appropriate, if not necessary, given the technical and specialized nature of the subject matter and terminology involved. U.S. v. ITT Continental Baking, supra, 420 U.S. at 240. Pursuant to Minn. Stat. § 14.60(2), the Court Monitor noticed and introduced as part of the record or indicated that he may rely on several publications or documents. These included Minnesota-based[14] and nationally recognized standards, texts or treatises[15] to aid him in his fact finding, generally, and in determining what constitutes appropriate programming for Welsch class members. Court Monitor's Ex. D, p. 3, (note), Tr. 3/6/85, pp. 5, 7.

2.2 A review of relevant portions of the record (including the professional testimony and publications) demonstrates three overriding and interrelated points. First, a unanimity of opinion exists that a properly developed and executed IHP is central in serving the needs of persons who have traditionally been classified in the moderate, severe or profound range of mental retardation.[16] Second, there is virtual unanimity of opinion that in order to assure proper development and implementation of an IHP (so that the intended purpose is fulfilled), certain basic components are necessary which are

discussed in detail in Part II(D) below and are generally stated in Part II(C)(6), supra. These components include assessment, goal selection, measurable objectives, implementation strategy, and evaluation. Third, these components are all generally reflected or incorporated in the vast majority of both "minimal"/ legal or regulatory rules as well as what are considered contemporary professional standards or practices.

2.3 The latter point is made in Program Issues . . . Resource Manual for [ICF/MR] Surveyors and Reviewers (see note 13):

> Recent court litigation, federal and state legislation, and accreditation and licensing standards require individualized program plans. The requirement is understandable in light of the recent attempts to increase the quality of service and insure active treatment for persons with developmental disabilities. Moreover, the requirement for IPPs in ICFs/MR is similar to mandates in other educational and human service agency program. The individualized education plan (IEP) is required by the Education for All Handicapped Children Act, and the Supplemental Security Income program requires the development of an individualized service plan (ISP). Similarly, the individualized written rehabilitation plan (IWRP) is mandated by the Rehabilitation Act of 1973, and developmental disabilities legislation requires development of the individualized treatment plan (ITP).

Id. at 108 (emphasis added). In other words, whether one relies solely on the expert testimony in the proceeding, professional or government/legal standards, the conclusions are the same -- that an IHP is essential and certain basic requirements must be met to assure that it is developed and carried out effectively. As is further pointed out in Program Issues: "Without meaningful and individualized IPPs, it is inevitable that the facility will fail

to provide residents with 'active treatment'." Id. at x (emphasis added). As is further stated:

> Like active treatment, individualized program planning is a process which includes assessment, planning, delivery, and evaluation of services by an interdisciplinary team. One of the most important parts of the individualized program planning process is the development of the written program plan which outlines the habilitation services required by the resident as well as the manner in which they will be provided.

Id. at 108.

2.4 Lyle Wray, Ph.D., Mary Kudla, and Robert Johnson were called as witnesses by plaintiffs and testified on the components needed in an IHP to assure that the individual needs of class members are appropriately met. They have all been or were at the time employees of the Department of Human Services and/or the state hospitals, and as such, have provided direct or indirect services to class members as well as extensive consultation, training, technical assistance, and/or quality assurance to mental retardation personnel. By virtue of their experiences, backgrounds, and training, they are all particularly well suited to testify and elaborate on the requisites of the development and implementation of the IHP and program in the context of this proceeding and as applied to the Welsch class. See plaintiffs' proposed findings 4.3-4.7.

2.5 They were all unanimous in their opinion that in order to appropriately meet the individual needs of all or nearly all class members, that an IHP and program must, without exception, include the following components: assessment, goal selection, measurable objectives, implementation strategies, and evaluations. See plaintiffs' proposed findings 4.9-4.11. Mr.

Nord, who like Ms. Kudla, occupied one of the three technical assistance positions called for by paragraphs 28-33 of the Welsch Decree, was called by both parties with respect to his involvement and judgments about Hearthside. Mr. Nord still occupies one of the three technical assistance positions and was recently designated the Welsch compliance officer in the Department, replacing John Clawson and his predecessor, Warren Bock. Plaintiffs' counsel also questioned Mr. Nord about the components of an IHP. He agreed that plaintiffs' proposed standards reflected professional and legal standards. Plaintiffs proposed findings 4.12. Mr. Nord and Mr. Johnson (see II(D)(4)) were also asked about and stressed the need to ensure that implementation strategies include procedures to assure that skills can be generalized or applied to environments in which they are naturally used, and are maintained thereafter.

2.6 In January 1980, the Department under a grant from HEW, compiled and published Minnesota Model Standards the Development, Testing and Evaluation of a Proactive Quality Assurance Mechanism for Facilities for the Mentally Retarded Final Report (1980). Court Monitor's Ex. A. The project was supervised by Dr. Bock. Its purpose was to develop uniform standards of quality assurance for residential facilities. Id. at iii, 1-3. While the standards and quality assurance mechanism proposed therein were ultimately not adopted, the document and findings are significant for at least three reasons. First, it was developed under the auspices of the Mental Retardation Division of the Department and completed in 1980, shortly before the

Decree was negotiated and signed. Second, numerous existing standards were culled, including ICF/MR, Health Department Rule 34 regulations, and ACMRDD standards, for the purpose of creating unitary standards. Id. A total of 1,023 requirements were examined. Id. Third, a wide cross section of experts and professionals from every level and part of the service delivery system in Minnesota reviewed the standards to determine both what should be included and in what order of importance. Id. at 7.

2.7 Twenty-two (22) categories for assuring the proper operation of residential facilities were grouped and ranked. These categories included life safety, clothing, sanitation, legal rights, etc. Id. at 13. Out of the 22 categories, the item that received the highest ranking was Individual Program Plans and Services, followed by Behavior Management. The need for Comprehensive Assessments and Staffing were ranked fourth and sixth, respectively. Id. The specific subcomponents for each category were set forth in some detail. See Court Monitor's Ex. A, pp. 27-30 and 44-46 on the subcomponents for Assessments, Individual Programs Plans, Record Keeping, and Staffing Patterns and Personnel. They are in general accord with the requirements of paragraph 24 as set forth herein.

2.8 The Department's August 1980 Six Year Plan hereto as Appendix B described Individualized Program Planning as one of several national trends which had its roots in the 1960's, if not earlier, came to "fruition" in the 1970's and "will clearly lay the foundations for the practices in the 1980's." Appendix B, p. 46. It further goes on to state that the components of the IPP or IHP must include:

> . . . the objectives to be obtained by the service to the specific person, the means that will be employed, and the resources that will be applied, and the means whereby attainment of the goals will be measured . . . these plans are generally mandated in detail as to the content, method of their development, and participation of the principle people involved.

Id. at 47-48.

2.9 Professor Robert H. Bruininks, et al., a professor at the University of Minnesota (and nationally known in the mental retardation field), pointed out in 1980 that "[t]he concern for individualized programming is overriding in the literature." Citations omitted. Bruininks, R. H., et al., Deinstitutionalization and Community Services, reprinted from Wortis, J., Mental Retardation and Developmental Disabilities, Vol. XI, New York: Brunner/Mazel, Inc. (1980), p. 15. He goes on to state:

> [A]ll program planning should include the following components: (a) assessment of each child's needs; (b) specification of those needs in terms of behavioral objectives; (c) written, step-by-step programs for fulfilling those needs; (d) a time frame for their fulfillment; (e) names of those designated to teach, train, or treat the child so as to fulfill those needs; (f) methods used; and (g) measures used.

2.10 VanBiervliet, P. and Shelden-Wildgen, J., Liability Issues in Community-Based Programs. Baltimore: Brookes Pub. Co. (1981) and Bernstein, G., et al., Behavioral Habilitation Through Proactive Programming. Baltimore: Brookes Pub. Co. (1981) (see Court Monitor's Ex. D, p. 3.), from two somewhat different perspectives, underscore the importance of an IHP in a legal and professional context. They both specify that the essential components include assessment, long and short-term

goals and objectives, specificity of teaching methods, data collection, evaluation, and review. As a prefatory note to the list and description of the components, Van Biervliet states:

> The development of an appropriate and individualized written treatment plan for each client is one of the most important duties of any community center . . . . Each community center should determine its own state's requirements and comply with them. Below is a comprehensive description of how treatment plans can be developed, monitored, and evaluated. Following these recommendations should ensure compliance with most state requirements but all centers should obtain and follow their own state regulations to be legally protected.

Id. at 147 (emphasis added). Stressing the fusion or overlap between legal and professional standards, Bernstein, et al. state at 55:

> In recent years state and federal legislation and accreditation standards have required written individualized habilitation programs for developmentally disabled individuals. The most far-reaching of these mandates were enacted by PL 94-142, the Education for All Handicapped Children Act. PL 94-142 specifically addresses children between 3 and 21 years of age. There are, however, many handicapped individuals who are over 21, and thus do not fall within the age guidelines of PL 94-142, who receive services from the Departments of Social Services and Vocational Rehabilitation and other private and public agencies. The authors believe that the principles outlined in PL 94-142 directly apply to the appropriate delivery of services to handicapped adults. In fact, many of the same principles are outlined in accreditation standards and state statutes (laws).

The standards of the Accreditation Council for Facilities for the Mentally Retarded (ACFMR) (see Court Monitor's Ex. D, p. 3) a national accreditation agency for facilities for persons with mental retardation operated under the auspices of the JCAH, stress the critical importance of the various components to the

IPP process in assuring that the needs of mentally retarded persons are met. Recognizing, like other standards, that providing for a person's needs is multi-faceted, and emphasizing the central role of the IPP process, the following is noted:

> The primary mission of each agency serving developmentally disabled persons must be to provide and promote services that enhance the development of such individuals. Fulfillment of this mission requires:
>
> . an interdisciplinary process for individual evaluation, program planning, and program implementation;
>
> . assessment of the individual's developmental status and needs, as a basis for designing and maintaining a program that will enhance development;
>
> . provision of services and interventions in accordance with developmental principles and the principle of normalization;
>
> . effective coordination of services, reflecting planned and active participation of the developmentally disabled individual and, when appropriate, participation of the individual's family or advocate; and
>
> . maintenance of functional records that are indispensable for effective programming.

Id. at 1 (emphasis added).

2.11 Finally, it is of more than passing significance that Judge Larson had this to say about the role and make-up of an IHP in the habilitation process: "Besides sufficient personnel and adequate equipment, an essential part of the habilitative process, agreed upon by witnesses for both sides, is an individualized written habilitation, or program, plan for each particular resident. Such plans should contain specific, detailed information about a resident's abilities, program goals,

and methods of attaining these goals." Welsch v. Likins, supra, Findings . . . (4/15/76), p. 26. See also note 5.

3. Rationale for Properly Developed and Implemented IHP's in Relation to Needs and Make-up of Class

3.1 Habilitation has been defined as the process by which a resident is assisted by others to acquire and maintain skills that enable the resident to cope more effectively with the demands of his own person, with his environment, and to raise the level of his physical, mental, behavioral, and social efficiency. Habilitation includes, but is not limited to, formal, structured programs of education and treatment. Welsch v. Likins, supra, Memorandum Findings (October 1, 1974), Appendix A to said Findings, p. 1.

3.2 Habilitation grew out of the recognition, now dating back over 30 years, that persons with mental retardation, including the most severely handicapped, have the demonstrated ability to learn and develop functional skills in a variety of life and vocational domains. Wray Tr. 12/21/84 (AM), pp. 11-12; Welsch v. Likins, supra, 373 F.Supp. at 495; Matson, J. and Mulick, J. (Eds.), Handbook of Mental Retardation, Pergamon Press, 1983, p. 339 (see Court Monitor's Ex. D, p. 3). Previously, a self-fulfilling view of mental retardation as a static condition, was used to justify custodial treatment. Matson and Mulick, supra, at 339; Garrity v. Gallen, 522 F.Supp. 171, 214 (D.N.H. 1981).

3.3 Dr. Wray noted that the recognition of the learning abilities of persons with mental retardation, which is known as "the developmental model", has been one of the key

developments in the mental retardation field in recent history. It has, of course, spurred major legal and policy reform in the legislative and judicial branches of the federal and state governments. See Cleburne v. Cleburne Living Center, supra, 87 L.Ed.2d at 322.

3.4 In essence, because of the clear and universal consensus that the learning and adaptive behavior deficits of persons with mental retardation could be addressed (Wray Tr. 12/21/84 (AM), pp. 11-12), primary attention of the service system changed to, and has remained, focused on habilitation; and as the central feature thereof, the development and implementation of habilitation plans.

3.5 Habilitation efforts are, of course, aimed at improving skills and behaviors which allow increased function, independence and normal living. Matson and Mulick, p. 339; Lakin, K. and Bruininks, R. (Eds.), Strategies for Achieving Community Integration of Developmentally Disabled Citizens, Paul H. Brookes, 1985, p. 73. The major domains that are addressed in an IHP may vary with age, but generally include communication skills, self-help skills, socialization, activities of daily living, academic skills, social, community and leisure and recreational skills as well as vocational and social responsibilities and performance. Johnson Tr. 2/6/85, pp. 38-39; see Grossman, H.J. (Ed.) Manual on Terminology and Classification in Mental Retardation. Washington, D. C.: American Association on Mental Deficiency, 1983, pp. 25-26.

3.6 Suitable and adequate treatment includes a properly developed IHP (Welsch v. Likins, supra, 373 F.Supp. at

493, 495; Welsch v. Likins, supra, Findings . . . (4/15/76), p. 26; Wray Tr. 12/21/84 (AM), pp. 11-12) which must be carried out in an aggressive and organized manner. ICF/MR regulations and interpretive guidelines, Appendix C, Introduction. Appropriate learning and environment opportunities must be provided persons with mental retardation because of the very intellectual and adaptive behavior deficits which define the disability. This is especially so for individuals who are severely and/or multiply handicapped. Welsch v. Likins, supra, Memorandum Findings . . . (October 1, 1974), pp. 4-5.

3.7 Several corollary principles have emerged which serve as both a means and end of service provision. The first principle is normalization, which this Court has characterized as "a basic component of the habilitation process . . . in which living conditions, appearances and activities of mentally retarded persons should generally approximate those found in the rest of society." Welsch v. Likins, supra, Memorandum Findings . . . (October 1, 1974), p. 5. As discussed below, the principle is not only important as a philosophy and as a guiding force to ensure privacy, dignity, and participation and integration in community life, but as part of an instructional strategy as well. Id.

3.8 The principles have several applications and implications to the IHP process which, as will be noted below, were addressed in the expert testimony. The IHP should be aimed at --

-- Increasing a person's adaptive behavior and independence;

-- Increasing a person's abilities in order to enable him/her to progress to more independent and less restrictive environments;

-- Promoting and specifically including opportunities for interaction and integration with non-handicapped persons; and

-- Achieving the above goals by including teaching strategies, formal and informal, which promote and indeed include opportunities for interaction and integration in natural, functional, and/or community environments.

3.9 Closely connected with principles of habilitation and normalization is the principle of the least restrictive alternative. This also is incorporated in the ICF/MR regulations and not only requires that the person's current environment be least restrictive, but shapes the direction and content of the current habilitation plan. As stated in the 1982 ICF/MR Interpretive Guidelines:

> The objective of the small ICF/MR is to serve as a more open, community interactive environment and to serve as a less restrictive setting than other larger facilities. Appropriateness of continued placement in the small ICF/MR should be viewed as a transition, leading toward ever less restrictive settings whenever possible and appropriate.
>
> * * * Each resident's plan of care must include an assessment of his potential for functioning outside the facility, specifying the type of care and services that will be needed to enable the individual to function in a different environment.

Appendix D, p. 420.

3.10 Rule 34, like the ICF/MR regulations, reflect the interrelationship of these principles. The Department, in

proposing amendments to Rule 34 after the enactment of the Community Social Services Act, stated the following:

> Rule 34 establishes statewide standards for the primary living units. It provides for individualized program planning for all residents and clearly requires that individual programs are to be carried out in a home-like atmosphere, in the least restrictive setting needed for an effective program. The Rule requires that developmental and remedial services be provided in addition to resident-living services outside the residential facility (i.e., Developmental Achievement Centers, sheltered workshops, schools, employment), whenever possible. This provision covering services outside of the residential facility addresses opportunities for a normal existence in order to make available patterns and conditions of everyday life as close as possible to the norms and patterns of mainstream society.

See Proposed Amendments to Rule 34, 5 State Register 411 (September 15, 1980); Adoption of Proposed Amendments to Rule 34, 5 State Register 1888 (May 25, 1981), Statement of Need and Reasonableness attached thereto, p. 2.

3.11 Similar standards and principles are embodied in the three versions of Rule 185, including the 1980 one as well as the most recent one. See generally Dept. Ex. 4, pp. 345-346, 348-349, and Ex. 70, pp. 3, 13-16. These include:

-- Provision of services to enable a person with mental retardation to live "a normal existence" or one that is "least restrictive", including "making available to him/her patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society." Dept. Ex. 4, p. 346. As stated in the 1984 version, provision of services in environments in which "[t]he physical surroundings, methods of interaction between the provider and employees . . . and the materials used in training are appropriate for the person's chronological age." Ex. 70, p. 3.

-- Providing a person with mental retardation "an individual service plan which is designed to acquire new and progressively difficult skills." Dept. Ex. 4, p. 346.

-- Provision of services which are "designed to increase interactions between persons with mental retardation and persons who do not have disabilities by using facilities, services, and conveyances used by the general public." Ex. 70, p. 30.

-- The individual service plan "must be based on a comprehensive assessment of needs, and annual evaluations to determine appropriateness and effectiveness of the . . . plan." Dept. Ex. 4, p. 346.

-- Are provided in "the type, quantity, and frequency . . . to achieve the results set forth in a person's individual service plan." Ex. 70, p. 3.

-- An individual service "plan must be designed to result in vocational or pre-vocational training appropriate to the person's chronological age and, to the extent possible, employment and increased financial independence." Ex. 70, p. 13.

3.12 The goals, objectives, and guiding principles of the Six Year Plan developed by the Department also demonstrate that services developed in the community should be appropriate and include principles of independence, least restrictive alternatives, and normalization. This Plan, or more precisely, two nearly identical versions, are attached hereto as Appendices B and B-1, and entitled respectively "Six Year Plan for the Mentally Retarded, August 1980", and "Minnesota Department of Public Welfare Six Year Plan of Action, 1981-1987". The latter was included with the Department's "Biennial Budget Request, 1982-1983 for Mental Retardation Services", and dated January 1981. The August version was developed contemporaneously with the Consent Decree. This is clear because the drafts of the Consent Decree, which were furnished by plaintiffs' counsel in this proceeding and in Bruce L. and relied on by the Court, were all dated either in late July or in August 1980, and the initial Memorandum of Understanding is dated July 12, 1980. Moreover,

the Welsch v. Noot Consent Decree was already being cited in the August version as a basis for the Plan. Appendix B, pp. 16, 18. Indeed, in providing a historical perspective in the January version, the Department cited the Welsch suit and Decree as one of the prime reasons for the Plan and in an attached CSSA 1980 Effectiveness Report to the Legislature, explicitly stated that the "six-year plan of action has been developed to meet the Welch [sic] v. Noot mandates . . . ." Id. at 238. Welsch v. Levine, No. 472 Civ. 451, Court Monitor's Findings of Fact and Recommendations RE: TAP Vacancy (June 25, 1985), pp. 2-3; Ex. 71, pp. 2, 5, §§ III and III F.

3.13 The specific objectives and action steps in the plan(s) are discussed elsewhere in these Findings, and in particular in Part V(B); however, two points should be made at this juncture. First, the major goal of the Six Year Plan was precisely the same as several of the community provisions of the Consent Decree: "[T]he deliberate and systematic reduction of the number of mentally retarded people living in the state hospitals to not more than 1,850 by June 30, 1987; and the simultaneous development of sufficient and appropriate community-based residential and day program services . . . ." Appendix B-1, p. 133; see also Appendix B, p. 6.

3.14 Second, the principles underlying the plan show an intent to incorporate the qualitative principles in state standards and contemporary professional standards and practices in the service arrangement and development necessary to achieve the goals and objectives of the Plan. As the August version (Appendix B, pp. 5-6) states:

> This document represents the Department of Public Welfare's Six Year Plan for the development and provision of residential and day program services for the mentally retarded in Minnesota. The design of this plan, which focuses on the reduction of state hospital populations, has been influenced by contemporary thought on the most appropriate setting in which services should be provided to mentally retarded persons. Subsequently, the plan of action which follows has been developed with an endorsement of the following . . . principles [five of seven are quoted]:
>
> 1. People who are mentally retarded or otherwise developmentally disabled can learn skills that can reduce their dependency and increase their self-sufficiency.
>
> 2. Reduction of dependency and increase in self-sufficiency of people who are mentally retarded or otherwise developmentally disabled is based on availability of services that meet individual needs.
>
> 3. Services to people who are mentally retarded or otherwise developmentally disabled should be provided in [sic] environment which not only meets individual needs, but also provides a setting which is at [sic] least restrictive in meeting individual needs.
>
> 4. Service environment, individual programs and services to people who are mentally retarded or otherwise developmentally disabled should include patterns and conditions of normal every day life to the extent that the person's conditions and service needs allow.
>
> 5. Participation of the person in need of services and the family is vitally important to the planning and provision of services. This includes assurance that services developed are as close to the person's family and home community as is possible.

See also January version, Appendix B-1, p. 135.

3.15 The Department considers the normalization principle to be of overriding significance in judging services. In an appendix to the August Six Year Plan (see Appendix B, p. 47), the Department states: "The normalization principle has become a

guiding and shaping force nationally and is explicitly used as a yardstick for judging appropriateness of programs and their effectiveness."

3.16 As stated above, an important element of normalization from a philosophical, humanistic, as well as learning or clinical perspective, is ensuring a residential placement in a home-like environment. However, placement in a home-like environment does not automatically translate into assurances that individuals' needs will be met. A person can be provided custodial treatment or inadequate habilitative services in a beautiful setting as they can in a back ward of an institution. Central to the application of these principles is the development and execution of an appropriate habilitation plan. As has been indicated, the need for effective individual planning and implementation is especially important for class members, who like all persons, have unique needs, deficits, and strengths, but also have severe and/or multiple handicaps. See Cleburne, supra at 322; Wray Tr. 12/21/84 (AM), p. 40.

3.17 There was some testimony that the nature and rigor of the habilitation plan standards contained in such authorities as Rule 185, ICF/MR standards, and similarly in plaintiffs' proposals, may not be necessary or even desirable for mildy handicapped persons (see Wray Tr. 12/21/84 (AM), pp. 9-10; Kudla Tr. 12/21/84 (AM), p. 86), but, as mentioned above, the need for adherence to such standards/regulations for the vast majority of class members was clearly recognized (Id.), and has been long understood by defendants, who have, in turn, realized

the attendant service delivery implications. See August 1980 Six Year Plan, Appendix B, pp. 16, 18. In fact, the defendants themselves were of the belief that almost all of the class members who would be placed in the community would require, at least upon initial placement, continued ICF/MR level of care and treatment.[17] As was stated in the August 1980 Six Year Plan:

> The Welsh [sic] v. Noot consent decree and the MR six-year plan both call for the net reduction of approximately 800 persons currently residing in state hospitals. Those individuals are typically more severely handicapped than those living in the community and will, in nearly all instances, need an ICF/MR facility placement.

Appendix B, p. 18. See also Minnesota State Planning Agency's "Policy Analysis Series, Issues Related to State Hospitals No. 6", Court Monitor's Ex. I, pp. 11-20. See also Mental Retardation Program Division "Status Report" to Department of Public Welfare Advisory Council, September 16, 1982, p. 5, Section E.1.2, Court Monitor's Ex. M.

3.18 In summary, the goals of habilitation and related principles are to assist persons with mental retardation in the development and enhancement of skills and behaviors to maximize their human qualities, increase the complexity of their behavior, enhance their abilities to cope with their environment, achieve increasing functioning and independence within their current environments, and enable them to progress to even less restrictive and more independent environments and settings where possible. Wray Tr. 12/21/84 (AM), pp. 15-16; Nord Tr. 3/15/85, p. 44; Lakin and Bruininks, pp. 18-19; Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 66. While the pursuit of these goals for handicapped persons like Welsch class

members seems as obvious as they would be for the non-handicapped that has not always been the case. As mentioned above, persons with mental retardation have suffered from various forms of disfavored treatment and perceptions. Cleburne, supra at 322; Lakin and Bruininks, pp. 3-23. While, thankfully, these perceptions are giving way to more optimistic and accurate assumptions about severely handicapped persons and more dignified and home-like settings are being provided, the record and the overwhelming weight of professional opinion makes clear that the central cog in meeting needs is an effectively developed and implemented IHP.

D. Findings With Respect to Components of the Individual Habilitation Plan Process

1. Assessment

1.1 As with most, if not all, of the components of the IHP process, there was virtually no disagreement as to what constitutes a comprehensive interdisciplinary assessment. Indeed, the testimony reflected the basic professional standards and literature as well as federal and state standards to include ICF/MR, Rule 34, and Rule 185 requirements. For example, the Rule 185 version in effect when the Consent Decree was executed defined assessment services as:

> b. Assessment services: The systematic determination of pertinent physical, psychological, vocational, educational, cultural, social, economic, legal, environmental and other factors of the mentally retarded person and his/her family; to determine the extent to which the disability limits can be expected to limit the person's daily living and work activity; to determine how and to what extent the disabling conditions may be expected to be minimized by services; to determine the nature and scope of services to be provided; to select service objectives which are commensurate with an individual service plan of action. It is to be

> followed at whatever intervals are needed by periodic reassessment; services are to be provided whenever necessary in the life of the individual. Assessment services are directed toward the effects of the disability and toward maximizing life functions in the face of remaining conditions.

Dept. Ex. 4, pp. 350-351.

1.2 The mechanics and type and nature of the evaluations are set forth in more detail in the ICF/MR regulations and in Rule 34. See, e.g., 42 CFR 435.1009, 442.454, 456, 463, 474, 482, 486, 489, 491, 494, and 496 and Interpretive Guidelines thereto, Appendix D. With regard to Rule 34, see Ex. 86, 9525.0330.

1.3 Program Issues . . . Resource Manual for Surveyors and Reviewers states that the assessments, which are used as the basis for the decisions of the interdisciplinary team, must be comprehensive and should permit determinations about:

-- strengths and needs of the resident;

-- extent of disability or disabilities;

-- recommendations for specific services which would enable the resident to achieve maximum developmental growth;

-- the most effective teaching/habilitation methods;

-- continued need for existing level of restriction or care versus placement in less restrictive environment(s). Id. at 114-116, 132-133.

1.4 The expert testimony did not cover the "waterfront", but focused primarily on those areas of the process in which the class members' assessments were particularly deficient. In effect elaborating on portions of legal and professional standards, the experts addressed three broad elements.

1.5 First, there was a unanimity of opinion that the assessments should enable determinations to be made about (1) the person's needs, deficits, weaknesses, strengths, preferences, interests, reinforcers, capabilities, and potential (Wray Tr. 12/21/84 (AM), pp. 12-14; Kudla Tr. 12/21/84 (AM), p. 71; see also Program Issues, pp. 132-133); and (2) the nature and demands of the current as well as future environments and activities in which the person is or will likely be functioning (Wray Tr. 12/21/84 (AM), pp. 14-16, 18; Kudla Tr. 12/21/84 (AM), pp. 73-75; Johnson Tr. 2/6/85, pp. 34, 36, 39-42, 50-51, 57; Nord Tr. 3/15/85, pp. 247-248).

1.6 The second area of testimony addressed the process and procedures used to do the assessment(s). These include:

(a) The completion of a standardized instrument evaluating a client's behaviors and skills in various activities or domains such as daily living, hygiene, recreation, social behavior, vocational, cognitive, etc. Wray Tr. 12/21/84 (AM), pp. 12-13. The instrument must be valid and appropriate for the particular client group. Id. See also Kudla Tr. 12/21/84 (AM), pp. 71, 73-74; Nord Tr. 12/21/84 (PM), pp. 11-12; Johnson Tr. 2/6/85, p. 34. As discussed below, the evidence shows that there is an over reliance on this instrument in fashioning the goals and objectives of the IHP. The testimony from the professionals was unanimous that the results of a standardized test is one input in the process and should not alone dictate program goals and objectives.[18] Id.; Program Issues . . . Resource Manual for Surveyors and Reviewers, pp. 77-78.

(b) Professional and non-professional evaluations, opinions, and recommendations are to be obtained and used. As to the former, the ICF/MR and Rule 34 standards provide, for example, that evaluations may include speech, audiological, occupational therapy, physical therapy, medical, dental, and psychological needs. Exactly what is included and whether or not specialized evaluations are required (e.g., orthopedic, neurological, pharmacological), are obviously dictated by the needs of the individuals. Evaluations, views, and recommendations are obtained from the client, his or her family, guardians and direct care staff who know him best, particularly with respect to his/her "strengths, needs, interest, and preferences" because it is these individuals who "have the day-to-day knowledge . . . [which] is essential for both assessment and goal planning." Program Issues . . ., p. 85.

(c) The assessment process culminates at the interdisciplinary team meeting where the relevant professionals, case manager, resident, guardian, family members, and direct care staff, through an exchange and cross fertilization of views and information, design the components of the individual habilitation plan. Wray Tr. 12/21/84 (AM), pp. 16-17, 21; Nord Tr. 3/15/85, pp. 247-248, 257; Program Issues . . ., pp. 115-118.

1.7 Third, the comprehensiveness of what is assessed as well as how well the process works both prior to and during the team meeting, will determine not only the overall quality and validity of the person's long-term and annual goals, but the short-term objectives, methods of instruction, and frequency of

evaluations as well. See ICF/MR regulations, 42 CFR 442.463, Appendix D, p. 95.

1.8 The witnesses indicated how interests or preferences influence teaching strategies. Dr. Wray testified to being able to teach a woman to sign "coffee drink" within five minutes when it was discovered that she liked coffee very much the first thing in the morning whereas previous attempts to teach signing had failed. Wray Tr. 12/21/84 (AM), p. 28. Mr. Johnson noted that he would not likely be successful in teaching a handicapped person a leisure skill that he/she did not prefer. Johnson Tr. 2/6/85, p. 27.

1.9 Likewise, both these witnesses testified that individual physical and mental handicaps must be taken into account in developing teaching strategies. As Dr. Wray pointed out, one should not attempt to teach someone a skill that he/she lacks the ability to perform. Wray Tr. 12/21/84 (AM), pp. 28-29.

1.10 Five points were stressed about the "how, what, and why" of assessments. First, the witnesses elaborated on the clinical rationale for looking and planning beyond current settings to less restrictive ones. As discussed above, and as Dr. Wray pointed out, the purpose of habilitation is to promote growth and development so that the individual improves upon or develops new skills and capabilities in order to become independent in current environments as well as to be able to function in future, less restrictive environments. However, because persons with mental retardation often do not acquire skills rapidly, as part of the assessment process, prospective environment(s) must be reviewed for the demands it will place on an individual. Then

goals, objectives, and teaching strategies can be developed to address those demands, or compensate for them. Wray Tr. 12/21/84 (AM), p. 15-16, 18. See also Johnson Tr. 2/6/85, p. 34, 36; Nord Tr. 3/15/85, p. 247-248. In ICF/MR terms, as noted in Program Issues . . .,

> . . . the team should consider the resident's current strengths and needs, then define the residential setting and support services which would enable the resident to live in a less restrictive setting. In some instances the postinstitutionalization plan will list the skills which the resident should acquire while (not before) living in a new setting.

Id. at 116 (emphasis in text). However, a word of caution is struck:

> Survey and independent professional review teams should question the staff about postinstitutionalization plans which require the resident to develop certain skills before placement in a less restrictive environment. Although acquisition of more complex skills will facilitate the movement to less restrictive settings, most residents of the ICF/MR could live in less restrictive settings if the proper support services were provided. The provision of support services and the careful structuring of the environment (rather than resident skills) determine whether residents can move from more to less restrictive environments.

Id. (emphasis in text).

1.11 Second, this point was also noted in the testimony in several related contexts. Because of a person's mental retardation and/or other handicap(s) (e.g., sensory, auditory, mobility), providing instruction through the normal sequence of skill development may take an unduly long period of time (Wray Tr. 12/21/84 (AM), pp. 41-44), or be impossible (training non-ambulatory persons to run in a marathon). Thus, in planning for current or future activities or environments in which an indivi-

dual may be participating, the assessment process should consider one or more of the following strategies to allow for partial or full participation or involvement in a greatly shortened time period.

-- Determine whether or not a particular skill is actually necessary for participation in an activity (see Wray Tr. 12/21/84 (AM), p. 41-44). As Dr. Wray noted, it might take years to teach a person to make change in order to take a bus. As an alternative, he suggested the possibility of teaching the person to put the coins in a plastic template.

-- When full participation or involvement in an activity is not possible, accommodations or adaptations can be made or skills taught to allow for partial participation. See Bernstein, et al., pp. 42-43. Illustrative of this, Dr. Wray pointed out, would be someone who has physical dexterity problems, but who could put his/her clothes on with someone else doing the buttoning or zipping. Total completion of that activity may even be possible by using an adaptation such as velcro fasteners in lieu of buttons or zippers. A slightly different accommodation to allow a non-ambulatory person to fully compete in a marathon would be establishment of a wheelchair division.

1.12 A third theme in the assessment and overall individual habilitation process is "individualization", which Dr. Wray characterized as one of the major developments in service delivery of the past 25 years. Like all persons, mentally retarded and severely handicapped individuals have unique

interests, needs, preferences, and desires. Wray Tr. 12/21/84 (AM), p. 40. The uniqueness and complexity is compounded by the level or multiplicity of handicaps. Matson and Mulick, pp. 215-219. See also Kudla Tr. 12/21/84 (AM), pp. 67-68. Without attention to these unique qualities, objectives, programs, and teaching strategies may be ineffective. Id. See also Program Issues . . . Resource Manual for Surveyors and Reviewers, pp. 67-68.

1.13 Not surprisingly and frequently, the complex and multiple nature of a person's disability makes valid and reliable assessment more difficult. This is, in part, why standardized behavioral instruments alone are frequently far from adequate to perform the assessments necessary to develop a program. Hence, the fourth point emphasized by the witnesses and the legal and professional standards, is the need for an interdisciplinary approach which recognizes the importance of a number of inputs, as well as their "cross-fertilization". As mentioned above, the general sources of information and input come from standardized assessments, professional and non-professional evaluations, and input from the consumer, family members, direct care staff, or other individuals who may be most knowledgeable about the individual on a day-to-day basis. The latter group of individuals are frequently in the best position to provide a variety of information of what interests and reinforces the client. Kudla Tr. 12/21/84 (AM), p. 71; Program Issues . . ., p. 75. The interdisciplinary approach, including the actual team meeting, is not only essential to hone in on the characteristics of the person,

but to fulfill the purpose for which the assessment(s) is undertaken, to design an IHP program. Nord Tr. 3/15/85, p. 247-248, 257; Wray Tr. 12/21/84 (AM), p. 16-17, 21; Program Issues . . ., pp. 133-134. Both the 1977 and 1981 versions of the ACMRDD Standards for Services for Developmentally Disabled Individuals define the interdisciplinary process as follows:

> The interdisciplinary process is an approach to diagnosis, evaluation, and individual program planning and implementation in which professional and other personnel, including the individual being served and, when appropriate, the individual's family, participate as a team. Each participant, utilizing the skills, competencies, insights, and perspectives his or her training and experience provide, focuses on identifying the development needs of the individual and devising ways to meet them, without the constraints imposed by assigning particular domains of behavior or development to particular disciplines only. Participants share all information and recommendations, and develop, as a team, a single, integrated individual program plan to meet the individual's identified needs.

1977 version at 2. Dr. Wray gave an example of the importance of an interdisciplinary approach for a person with a seizure disorder. Wray Tr. 12/21/84 (AM), p. 17. In such an instance, input or participation of a nurse or physician would be important. However, a psychologist or special educator together with direct care staff or friend may be able to provide input which would lead to a training program to teach a person to self-administer medications. Thus, an important skill is taught which affords the individual more independence either in his/her current environment or perhaps in permitting him/her to move to a less restrictive environment. In the case of a multiply handicapped adult a "cross tabulation" (Wray at 17) between occupational therapy and vocational disciplines allows for the

use and improvement of fine motor skills in meaningful vocational activities, as is indicated in Program Issues . . .:

> [A]ctivities to provide training in grasp and release for an older handicapped person should be provided within the context of vocational training. The resident's program might involve manipulation of nuts and bolts or sorting objects or simple assembly tasks which would provide practice in grasp and release. Vocational training is preferable to teaching grasp/release through bead stringing, or block stacking, or other types of child-like activities. Vocational training activities are age-appropriate and more relevant to the person's ultimate goal of increased independent functioning.

Id. at 141.

1.14 Fifth, while the discussion of the assessment and the individual habilitation process frequently focuses on the acquisition of new skills to enhance functioning, this process is also an essential element to identify and address needs and skill areas for health, safety and survival. Kudla Tr. 12/21/84 (AM), p. 72. Examples given by Ms. Kudla are teaching a client how to dress according to the weather and when to evacuate a building. Id. An interdisciplinary and behavioral approach is used for addressing eating disorders (or teaching swallowing), which can be life threatening. This is the frequently the case whether the origin of the problem is behavioral, neuromotor, or physical. Hollis, J., Meyers, C., Life Threatening Behavior: Analysis and Intervention, Monograph of the American Association on Mental Deficiency (1982), p. 3, 4-22.

1.15 If done correctly, an assessment, while only the first step in the individual habilitation process, sets the framework for the development of the goals, objectives, and strategies to assure that a client's needs are met.

1.16 Therefore, in developing an IHP to assure that a community placement appropriately meets the individual needs of class members, there must be a comprehensive assessment of the individual's needs, strengths, deficits, interests, reinforcers, and capabilities through appropriate standardized tests, formal and informal evaluations, interviews, information gathering, and analysis. The assessment must identify individual needs which if remediated, compensated for or accommodated will assist the individual to function and participate more independently and fully in his/her present and future environments. To the extent expert or professional assistance is necessary to determine particular needs, expert or professional personnel must be involved in the assessment process.

2. Goal Selection

2.1 As above, the expert testimony, professional and legal standards, and literature, demonstrate a unanimity of consensus on the necessity, purpose, and function of goal selection. "Goals are extracted from and related to the resident's need list" developed during the assessment process. Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 116. It is not until the team meeting, however, that the actual goals are decided upon and established.[19] Nord Tr. 3/15/85, p. 257; Wray Tr. 12/21/84 (AM), pp. 20-21.

2.2 Four issues were highlighted. First, because of the nature of the habilitation process and its future orientation, as well as the relatively slower rate in which mentally retarded individuals acquire skills, long-term goals (3 to 5

years) as well as annual goals, are necessary for sound program planning. Wray Tr. 12/21/84 (AM), pp. 17-19, 41-44; Kudla Tr. 12/21/84 (AM), pp. 74-75; Nord Tr. 3/15/85, pp. 247-248; VanBiervliet, p. 150. As expressed by Dr. Wray, a long-range goal looks at where the person might expect to be living and what he/she might be doing in the future. Wray Tr. 12/21/84 (AM), p. 18. For example, a long-range goal may be supportive competitive employment in three years. Annual goals, as Dr. Wray put it, are then established to track the long-term goals and are based on a reasonable expectation of what can be accomplished within that period. Id. at 17-19. Using the vocational example, annual goals might be directed to enhancing production rates and/or they could be social/behavioral in orientation if improvement is needed in that area in order to allow for integration in the work place. Wray Tr. 12/21/84 (AM), p. 18. Work and home are not the only domains with which the team is concerned. Typically, other broad domains include community living and recreation and leisure. Johnson Tr. 2/6/85, p. 38.

2.3 Second, both long-term and annual goals must be age-appropriate, functional, future oriented, and aimed at enhancing independent and adaptive behavior. Kudla Tr. 12/21/84 (AM), pp. 74-75; Ex. 74 at 3; Ex. 75 at 3. As Mr. Johnson stated: "[I]n programming for mentally handicapped persons, one has to ask where the person's going to function and what skills the person needs to function there . . . ." Johnson Tr. 2/6/85, pp. 34, 36. Thus, with the emphasis on functional behavior and increased independence, the emphasis shifts from "stringing

beads" to daily living objectives "such as taking a bus, choosing clothing, crossing streets, performing specific, productive occupational tasks, . . . preparing a bowl of cereal in the morning . . . ." Lakins and Bruininks, p. 19. See also Kudla Tr. 12/21/84 (AM), pp. 75-77. Put succinctly by Ms. Kudla: "Functional goals are goals that are basically useable meaningful to the clients in the client's daily living environment, something that the client actually needs to do in order to function in that environment." Id. at 75. This emphasis is at the heart of the ICF/MR standards and active treatment which is "to help the individual function at the greatest physical, intellectual, social, or vocational level he can presently or potentially achieve." 42 CFR 435.1009 (b), Appendix D, p. 410. As elaborated on in Lakin and Bruininks:

> [I]t is increasingly accepted that educational and training programs for developmentally disabled persons should ultimately serve the same ends as those for normal people--they should maximize the individual's ability to function independently and productively. Today, the use of applied behavior technologies, observational learning, training in accurate recognition of stimuli, and the use of natural reinforcers in the direct teaching of daily living skills is producing results with developmentally disabled persons that were undreamed of when a more community-centered approach to services for developmentally disabled persons was gathering momentum in the 1960s. The use of this knowledge to continue and expand this effort is increasingly acknowledged as the moral, if not the legal, imperative for the habilitation programs provided in long-term care settings.

Id. at 19.

2.4 The third area of testimony focused on the need to prioritize the goals. The needs list produced during the assessment from which the annual goals are formulated may contain

numerous areas, not all of which can be worked on simultaneously. Therefore, a list of priorities must be developed. Johnson Tr. 2/6/85, pp. 34, 36. The goals and/or objectives that are selected should be ones that maximize independent functioning or address health and safety needs. As stated by VanBiervliet: "Thus, for example, a client with a serious medical problem may have as a number one priority the objective to either learn how to monitor the problem or how to take the proper medication to control the problem." Id. at 150.

2.5 Most persons will desire or have goals to increase function, independence, etc. in most if not all of the traditional domains: domestic/self-care, community, leisure, day/vocation. Beyond that, there should not be any set prescription on what the goals should be as they will vary depending on the needs interests, capabilities (etc.) of the individual.

2.6 However, the Connecticut decision (Appendix E) advises that goals and objectives must be consistent with the principle of "active treatment." Id. at 596-597. Thus, for example, while programs which teach increased independence or competence in handwashing or toothbrushing are important, over emphasis on such programs should be scrutinized carefully. Id.

2.7 The following questions posed by Program Issues . . . to review teams and surveyors to examine, summarize the criteria of goals selection.

1. Do goals promote development and increase complexity of behavior?
2. Are goals extracted from and related to the resident's needs list and not determined by diagnosis, label, or IQ?

3. Are goals consistent with the normalization principle, legal rights, and developmental programming?
4. Do goals reflect the skills each resident must possess in order to function as independently and productively as possible in the least restrictive living arrangement possible?
5. Are goals and/or objectives which are deferred because of lack of resources noted by documentation? (What additional resources are required? What efforts have been made to obtain the resources? What is the impact of deferment on the resident?)

Id. at 117.

2.8 Therefore, in developing an IHP to assure that a community placement appropriately meets the individual needs of class members, long-term and annual goals must be selected which, if achieved, will allow the class member to function and participate more independently and fully in his or her present and future environments. The annual goals, in particular, should be stated in measurable and behavioral terms. This goal selection process should be completed by an interdisciplinary team which includes:

(a) the class member,

(b) the class member's parent, guardian, or if possible, other family representative,

(c) the responsible county case manager,

(d) persons who interact with the class member regularly in the residential or day program, and,

(e) expert or professional personnel who direct involvement in the team planning process may reasonably be said to be necessary in order that appropriate judgments may be made in the goal selection process.

3. Short-term Objectives

3.1 Professional and legal standards and literature reveal an overwhelming consensus about the need and rationale for short-term objectives and the requisite components thereof. Wray Tr. 12/21/84 (AM), p. 22-24; Kudla Tr. 12/21/84 (AM), pp. 77-78. See also plaintiffs' proposed findings 4.27-4.29, pp. 79-80; ICF/MR regulations and Interpretive Guidelines, Appendix D, p. 507; 1984 version of Rule 185, Ex. 70, p. 19. State licensing requirements require well formulated objectives. See plaintiffs' proposed findings 4.28 and Ex. 74, p. 3; Ex. 75, p. 3; Ex. 76, p. 2. See also Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 117; ACMRDD Standards (1977 and 1981), p. 12.

3.2 Short-term objectives are midway on a hierarchy between the goals and the training methods or implementation strategies. Wray Tr. 12/21/84 (AM), p. 22.

3.3 The record in this proceeding emphasized three requisites or aspects to short-term objectives.

(a) The degree of specificity of the objective will vary with the individual's capabilities. Wray at 22-23. As stated in the ICF/MR guidelines: "Depending on the resident's stage of development, objectives should consist of target behaviors which proceed in steps from simple to more complex issues" (Appendix D, p. 507), and several objectives may be required to accomplish a single goal. Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 117. Similarly, depending upon the nature of the goal and objective(s) being worked on and the resident's capability, the increments between objectives may vary. For example, for the individual whose goal

is to learn to ride a bus independently may have as one of his/her short-term objectives learning how to use a template for change. See Wray Tr. 12/21/84 (AM), pp. 41-44. For an individual who is deaf/blind and "is able to stand with support but does not walk without assistance", the specific objective might be less ambitious, i.e., to walk to specific functional points in his home independently. See Program Issues . . ., p. 141.

(b) Objectives should be stated in measurable and behavioral terms, that is, there must be a clear description of the behavior so that different persons observing it can agree on whether or not it has occurred. Wray Tr. 12/21/84 (AM), p. 25-26; Bernstein et al., p. 88. A clear understanding of what behavioral deficit is being addressed is a precondition to assuring that the teaching strategies are carried out properly and measurement, data collection, and evaluation can occur effectively. Thus, using Dr. Wray's example, if the goal was to teach someone to wash themselves, a measurable objective might call for the individual holding a bar of soap in his hand for five seconds, six out of seven days a week, as opposed to he shall show improvement in the use of soap consistently over the week. See Wray Tr. 12/21/84 (AM), p. 25-26; Bernstein et al., p. 89. Included in this concept is a statement as to the conditions under which the behavior will be demonstrated. Program Issues. . ., p. 117. In the example, this may include picking up and holding the bar of soap when in the bathroom or immediately after entering the bathroom or upon request by the staff, etc. In terms of more complex or advanced behavior, the conditions would likely be broadened to other environments or settings, e.g.,

teaching a person to use or handle money in specified environments in the community. See Johnson Tr. 2/6/85, pp. 56-60.

(c) The objective should also include the criteria for determining achievement or performance and/or when it should be changed or continued. As Ms. Kudla explained, an objective for a client to learn how to make make a sandwich (in addition to specifying the manner and accuracy of the actual activity) would set forth a time to review and determine whether or not some aspect of the objective or teaching intervention should be modified or whether it should be deemed completed, etc. As she put it:

> Since the whole focus and purpose of an individual program plan is to teach clients skills which would make them more independent--less independent upon staff, you would want to specify the criteria for change or termination to know how well the client is doing. So don't go on teaching something they already know, or you don't waste, basically, their time.

Kudla Tr. 12/21/84 (AM), p. 78. The timeframe for objectives will also vary by the individual, based on past performance and what has worked in the past with similar clients using similar techniques. The timeframe for expected completion of the objective may be monthly, quarterly, or sometimes semi-annually. Wray Tr. 12/21/84 (AM), pp. 23-24.

3.4 Therefore, in developing an IHP to assure that a community placement appropriately meets the individual needs of class members, short-term objectives must be included and designed to result in the achievement of the annual goals developed for that class member. These objectives must be time-

limited and be stated so that measurable behavioral criteria can be used to determine whether implementation of that program has resulted in achievement of the objective.

4. Teaching or Implementation Strategies/Programming Coordination and Comprehensiveness

4.1 In order to ensure that the objectives and programs called for are carried out, it is necessary to specify the individualized instructional steps, methodologies or strategies. Nord Tr. 1/23/85 (AM), p. 13; Wray Tr. 12/21/84 (AM), p. 27; Kudla Tr. 21/21/84 (AM), p. 69. This component of the IHP is also considered basic[20] by professional opinion. See, e.g., Johnson Tr. 2/6/85, p. 26; Kudla Tr. 12/21/84 (AM), p. 70; ICF/MR Regulations and Interpretive Guidelines (1977 version), Appendix C, p. 330; 1982 ICF/MR regulations Interpretive Guidelines Interpretive Guidelines, Appendix D, p. 507; Program Issues . . . Resource Manual for Surveyors and Reviewers, pp. 71-72, 117-118, 215-216; Minnesota Model Standards, p. 29, § 2.3(c), Court Monitor's Ex. A.; 1984 version of Rule 185, Ex. 70, p. 19; 1980 version of Rule 185, Dept. Ex. 4, p. 346; Court Monitor's Ex. H, p. 2.[21]

4.2 Dr. Wray compared this component to a "recipe card" as it describes in very specific terms exactly what will be done by the staff, the expectations of the individual being trained, and what the staff will do depending on what the student or trainee is doing. Wray Tr. 12/21/84 (AM), p. 27. See also Kudla Tr. 12/21/84 (AM), p. 69-70. As Mr. Johnson put it, the need to write down the specific teaching steps is basic so as to

ensure that it will be carried out properly. Johnson Tr. 2/6/85, p. 26. IHP's cannot reasonably be expected to be effective if no intervention plan is specified. Kudla Tr. 12/21/84 (AM), p. 70. There is also a concomitant need, as Dr. Wray pointed out, to assure that it can be carried out by staff in a relatively self-executory manner without further explanation. Wray Tr. 12/21/84 (AM), p. 27. See also Nord Tr. 1/23/85 (AM), p. 13.

4.3 Several additional requisites or aspects of teaching strategies were addressed.

4.4 The first stressed the importance of individualization in developing the strategies. As stated above, one of the functions of the assessment process was to determine the interests, reinforcers, preferences, etc. of the individual so that they may be incorporated in the teaching strategy (as well as other components of the plan). Wray Tr. 12/21/84 (AM), p. 28; Johnson Tr. 2/6/85, p. 27; Bernstein et. al., p. 202; Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 136. A similar objective for different individuals would likely yield individualized or different teaching strategies.[22] See Kudla Tr. 12/21/84 (AM), p. 69. As Ms. Kudla stated:

> If a series of individuals needed the same objective to be met, one would assume there could be some similar teaching strategies or intervention strategies, but it would be highly unlikely that the exact same intervention or teaching strategies would be useful or would lead to learning for the client. It would be highly unlikely.

Id.

4.5 Second, standard practice, as reflected in all of the authorities, is that the intervention plan or methodology not only describes specific instructional strategy, but indicates who

is responsible (within each agency), for carrying it out. See, e.g., 1984 version of Rule 185, p. 19.

4.6 The third area of testimony focused on the need for procedures which assure that skills are (1) taught in and otherwise generalized to functional and natural environments in which they are to be used, and (2) that the skills and behaviors are then maintained by the individual thereafter. This is known as generalization and maintenance.[23] These principles are central to the purpose of habilitation and normalization and have implications not only for the development of proper implementation strategies, but for other components of the IHP process as well. Johnson Tr. 2/6/85, p. 59-60, 84-86; Nord Tr. 1/23/85 (AM), p. 78-82.

4.7 Federal ICF/MR regulations, as they apply to community facilities, emphasize the need for linkage and coordination between multiple providers of service because of the importance of "generalization." "Reports to and from outside resources should be as timely and frequent as necessary to ensure a flow of information sufficient to operate a comprehensive, consistent and continuous program of training, reinforcement, and generalization." Appendix D, p. 501. See also Id. at pp. 415-416, 463.

4.8 Messrs. Nord and Johnson, who testified about maintenance and generalization procedures, stated that it was important to incorporate generalization and maintenance procedures in the individual habilitation plan process, otherwise as pointed out by Johnson, "the chances are, the skill won't be

exhibited any other place than the place it was trained in." Johnson Tr. 2/6/85, p. 85; Nord Tr. 1/23/85 (AM), p. 82-84. As put by Liberty in Lakin and Bruininks:

> Gradually it has become clear, however, that most of the new skills fail to be maintained after instruction ceases. Even if skills maintain, most do not generalize to situations beyond the training situation, nor are they adaptable to differences in application required by different situations. Skills that are not maintained and not generalized and that cannot be adapted are useless to the learner, and the time and effort spent teaching them is a waste. Some have been tempted to attribute the failure to the learner. However, since acquisition can be accelerated with special strategies, it is just as likely that instructional plans can be remediated to produce skills that are maintained, generalized, and adaptable to new situations.

Id. at 29 (emphasis added). Concurring in the absolute necessity of maintenance and generalization, Bernstein et al., give two concrete examples of its import:

> An individual who has been taught how to work at a competitive rate but who is not capable of maintaining that rate over time is not going to be able to hold down a job. The person who knows how to cook dinner only on the stove in the group training home where he or she resides is not going to be able to feed himself or herself in an apartment.

Id. at 200.

4.9 Two primary points were made as to how the implementation strategies and the IHP as a whole ensures maintenance and generalization. First, the determination is made as to the different environments or settings in which the particular skill should be taught, and then the procedures and steps (e.g., staff responsible, number of trails, etc.) are set forth in writing in the IHP. Nord Tr. 1/23/85 (AM), pp. 78-80, 82-84; Johnson Tr. 2/6/85, pp. 84-85. By providing instruction in natural or

community environments, a person's participation and integration into normalized, integrated and less restrictive settings is promoted; and (b) instruction is facilitated and retention promoted and facilitated because reinforcers and rewards which naturally and perpetually exist can be used, e.g., receiving pay for assembly work as opposed to a sticker or tokens for placing pegs in holes in a classroom. As stated in Bernstein et al.:

> It is not functional just to teach people how to ride a city bus. It is functional to teach them how to ride a bus only if we teach them how to use that knowledge to get to work, to get to a movie, to go grocery shopping, to get to a friend's house, and so forth. It is not functional to teach people how to subtract three-digit numbers unless those three-digit numbers mean something. It is functional to teach people how to do enough three-digit addition and subtraction so that they can prepare a budget based on their income.

Id. at 201.

4.10 Second, for class members who are severely handicapped the need for a full and well-integrated program, not artificially limited by a prescribed number of hours, or in one setting versus another, is essential. As stated by Judge Larson: "At least for the severely and profoundly retarded, this program of habilitation and normalization should be carried on consistently during the waking hours. This would enable skills learned in formal training programs to be continued and reinforced during portions of the days during which there are no formal programs or activities." Welsch v. Likins supra, Memorandum Findings of Fact . . . (1974), p. 5. As stated above, this principle is reflected in the ICF/MR Interpretive Guidelines:

> Many providers of care seeking certification as small ICFs/MR contend that if the facility provides active treatment through a coordinated program of services conducted outside the facility, then it can be said to be providing active treatment services. Active treatment, though, as required by statute and defined in the regulations is a continuous, unified process which may involve both day services and the training activities which occur in the facility, both reinforcing each other so that the resident receives a comprehensive and consistent program of intervention. This requirement is founded in the well demonstrated knowledge that retarded persons require extensive training in the skills they need in all of the environments in which those skills will be utilized. This is called 'generalization training.' Thus, their need for training is not confined to five or six hour blocks of time.

Appendix D, pp. 415-416. An analogy would be expecting a child to become a good baseball player, but the only time he/she played baseball was in a weekly gym class. As stated in Program Issues . . . Resource Manual for Surveyors and Reviewers: "In order for training to be effective, it is absolutely essential that training be conducted in a regular, systematic, and consistent fashion. This means coordinating training across days, disciplines, shifts, and locations. In addition, training should be integrated, insofar as possible, into all aspects of the resident's daily life." Id. at 70-71.

4.11 More than an incidental benefit is realized by the effect a comprehensive and full day of habilitation has on remediating or preventing maladaptive behaviors, which, for some class members, is a major impediment to increased functioning and independence. As stated in Program Issues . . .: "The best defense against the appearance of problem behaviors is an active program that involves the resident in satisfying skill-building and development-enhancing activities." Id. at 71.

4.12 Finally, a recent journal article put it this way:

> Generalized skill performance is not a frill. It is a matter of critical importance in fostering adaptation to the demands of natural environments. Regardless of the number of potentially functional skills taught in an artificial training setting, instruction will be virtually useless unless those skills are also performed in natural environments (Braun et al., 1976; Liberty, 1985; Neel & Billingsley, 1981).

Billingsley, "Where Are the Generalized Outcomes? (An Examination of Instructional Objectives)", Journal of the Association for Persons with Severe Handicaps (1984), 9(3), 191.

4.13 Therefore, in developing an IHP to ensure that a community placement appropriately meets the individual needs of class members, for each objective in a class member's IHP there must be a written intervention plan describing specific individualized teaching steps and teaching strategies to be implemented in order to achieve that objective. It must include a projected schedule of implementation and name staff persons responsible for that implementation. The method to be followed must be developed with consideration of the class member's needs, interests and preferences, and physical and mental limitations. It must utilize methods and places of instruction or implementation (including, as appropriate, natural or community settings) which will assist the individual in generalizing and maintaining skills once and as they are acquired. As necessary, teaching strategies should be implemented across environments, shifts, and programs.

5. Review and Evaluation of Program

5.1 The necessity of review and evaluation to determine client progress in meeting objectives is clearly embodied in standards and literature, and the testimony reflected this fact. Wray Tr. 12/21/84 (AM), p. 32; Kudla Tr. 12/21/84 (AM), p. 78; Ex. 74, p. 3; Ex. 75, p. 3; Ex. 76, p. 2; Nord Tr. 1/23/85 (AM), pp. 12-13. See also Johnson Tr. 2/6/85, p. 75; 1982 ICF/MR regulations, Interpretive Guidelines thereto, Appendix D, pp. 420, 507; Rule 34, p. 7316, Ex. 86; and Program Issues . . . Resource Manual for Surveyors and Reviewers, pp. 88, 121. It was also generally acknowledged that the program review and evaluation had to be based on written information from the client's records, which in most cases, would have to be objective data, recorded and kept in sufficient detail to allow a class member's progress towards meeting the objective to be evaluated. Wray Tr. 12/21/84 (AM), p. 32. See also Johnson Tr. 2/6/85, p. 75; Program Issues . . ., pp. 88, 121-122; Rule 34, p. 7316, Ex. 86; Court Monitor's Ex. H, p. 11.

5.2 While the manner in which data is collected will vary according to the particular training program, there are common elements in an adequate data collection system. Wray Tr. 12/21/84 (AM), p. 32; Kudla 12/21/84 (AM), p. 78; Program Issues . . ., pp. 88, 121.

(a) As stated above, the behavior to be recorded must be defined with sufficient specificity so that two or more individuals would agree on whether or not it is happening. Wray Tr. 12/21/84 (AM), pp. 32-33. This underscores the importance of the need for measurable and behaviorally stated objectives and is

underscored by the authors in Program Issues . . . "Unless programming objectives are written in behavioral terms, it is impossible to assess the progress of a resident toward these objectives. Expression of objectives in behavioral, measurable terms is therefore another fundamental requirement of developmental programming and active treatment as required by the ICF/MR regulations." Id. at 70.

(b) The behaviors observed must be accurately recorded and done so in accordance with the stated instructions. Wray (Id.); Johnson Tr. 2/6/85, p. 75. A related point is made in the ACMRDD standards (1977):

> Because persons from a variety of professional backgrounds must use the individual's record in order to implement the individual program plan, entries in the record must be written in such a way as to convey meaningful information to all who are involved with the individual. The record should include objective data and reports of observable behaviors, rather than inferences, assumptions, and interpretations that may not be defensible.

Id. at 38.

(c) To ensure minimal error in recording, data should be recorded at the time the behavior is observed or soon after as possible. Wray (Id.); Program Issues . . ., p. 88. See also ICF/MR regulations and Interpretive Guidelines thereto, Appendix D, p. 453.

(d) The data on the client's progress and the program as a whole should be reviewed continuously as well as periodically or on the basis of a predetermined timeframe, per objective. The normal period for review is monthly, or quarterly. When a time-frame is set by the objective it is based on the team's judgment as to when they believe the objectives should be accomplished,

terminated, or changed. Kudla Tr. 12/21/84 (AM), pp. 77-78; ICF/MR regulations and Interpretive Guidelines thereto, Appendix D, p. 419; ACMRDD 1.3.7, p. 12; Minnesota Model Standards, 2.6, p. 30; Program Issues . . ., pp. 88, 121; Court Monitor's Ex. H, p. 9.

(e) Finally, staff must be adequately trained in implementation of the particular program and necessary data collection method, followed by supervision and observation of staff performance once implementation begins. Wray Tr. 12/21/84 (AM), pp. 32-37; Johnson Tr. 2/6/85, pp. 80-82.

5.3 The testimony amply demonstrated that the review and evaluation based on reliable information and data is the linchpin of assuring that the client's program is effective. See Wray Tr. 12/21/84 (AM), p. 32; Nord Tr. 1/23/85 (AM), pp. 12-13. It is essential to the assessment and IHP process as a whole[24], as indicated in Program Issues . . . Resource Manual for Surveyors and Reviewers:

> Interdisciplinary teams are required to develop the IPP as well as to evaluate its effectiveness in assisting the resident to achieve designated objectives. The planning and evaluation functions, however, can only be as good as the information upon which they are based. Effective planning requires quality assessment, and proper evaluation depends upon reliable data.

Id. at 122.

5.4 Programmatic data allow reliable determinations to be made about:

(a) Whether changes need to be made in the implementation strategy or the data collection process itself. Nord Tr. 1/23/85 (AM), pp. 12-13.

(b) Whether additional staff training is necessary. Program Issues . . ., p. 21.

(c) Whether or not the services are being provided on a concentrated or consistent basis. Id.

(d) Whether or not the objectives are appropriate. Id.

(e) Whether the timeframe for accomplishing the objectives is reasonable or the learning steps are too great. Id.

5.5 Bernstein et al., cite several other compelling reasons, two of which are worth noting.

> 1. Human judgments of what someone does are frequently inaccurate (Kazdin, 1975). We often are told that a client has temper tantrums all the time, only to find that the tantrums in fact occur once or twice a week. On the other hand, staff often become so used to a mildly irritating behavior that the behavior is seen as happening infrequently even though it really occurs several times a day.
> . . .
>
> 4. We have to know where we are in order to decide whether we've gone anywhere (Martin & Pear, 1978). If you don't measure what clients are doing before you start a program, measurements of their behavior after you start will be meaningless because you won't have any way to make a comparison. This is why baseline data are so important.

Id. at 102 (emphasis in text).

5.6 Therefore, in developing an IHP to ensure that a community placement appropriately meets the individual needs of class members, a class member's progress or lack thereof toward the objectives must be regularly reviewed, at least monthly or more frequently, as needed or prescribed, so that timely and necessary modifications can be made. Program records (including objective data) must be recorded with sufficient frequency and kept in adequate detail to allow the class member's progress toward the objective to be evaluated.

III. FINDINGS WITH RESPECT TO DEVELOPMENT AND IMPLEMENTATION OF INDIVIDUAL HABILITATION PLANS FOR CLASS MEMBERS AT HEARTHSIDE

A. Overview

1. When judged against the requirements of paragraph 24, as found herein, it is clear and generally undisputed that Hearthside has been deficient on a number of counts (see defendants' proposed findings 15; Ex. 59) although not all witnesses concurred on the implications of the deficiencies and the impact on class members.

2. The Recommendations (Part VIII) are necessarily designed to remedy the dificiencies, but they take into account and reflect improvements Hearthside has made, the strengths of the facility, some of which are inherent, others of which have been built through effort and an expressed desire and willingness on the part of the administrator, Mr. Abrahamson, to adequately provide for the needs of his residents, including the three class members (see Hearthside's finding 9). The physical environment is no doubt superior to MLSH (having viewed both facilities); the setting on Lake Vermillion is indeed attractive, and with the boathouse and greenhouse, both of which are multipurpose, Hearthside can offer recreational opportunities which many other programs cannot or do not. See defendants proposed findings 7. Potentially, with more resources, much more could be offered and class members, for example, could learn more self initiating behavior and take advantage of the opportunities presented by the setting.

3. Dan and Delores each share a room with one other person, while Mark had his own room. The rooms are appropriate

and Delores' room is very nice. The living room area of the Men's House, in which Dan and Mark reside, was not particularly inviting. While none of the three class members reside in the "log cabin", it was quite attractive.

4. Since plaintiffs' initial visit and report in October 1983, some improvements have been made. An intercom system between buildings, which had been in disrepair, was made operable, two additional staff have been added at night (the lack of which had been alleged by plaintiffs to raise safety concerns - Ex. 1, p. 4), and more family style dining was introduced. Ex. 8, p. 28. Additionally, by the time of the hearing, a new program format was adopted (Ex. 58, pp. 25, 29-30) and a consultant agreement was entered into with Geoffrey Ammerman, a licensed psychologist. Ex. 57, p. 24.

5. Unfortunately, these improvements or changes (as well as others) have not translated into significant improvement in the development and implementation of IHP's for class members. (Some, of course, were not directed to that area, e.g., repair of intercom system.)

6. The record, which was mainly constructed from the testimony or reports of DHS or St. Louis County personnel, reveal serious deficiencies in each area of IHP development and implementation. While defendants do not concede all plaintiffs' factual contentions, they do quite candidly admit: "In terms of the standards proposed by plaintiffs' counsel, they [Hearthside's programs] do not meet the standards in some respects, come close in others, meet in others, and exceed in others." Defendants'

proposed findings, p. 5. Indeed the record as a whole shows deficiencies in each and every area of IHP development and execution as well as staffing.

7. In a December 19, 1983 letter from St. Louis County Social Service Department Director Zeleznikar to Deputy Commissioner Giberson the County admitted virtually all of plaintiffs' allegations made in plaintiffs' October 1983 report. Ex. 8, pp. 27-32. See also Ex. 117, pp. 3-5.

8. In two documents, Exs. 53 and 54, the latter of which was sent to Mr. Abrahamson, Robert Chilberg, an employee of the Department's licensing division, set forth the findings made by him, Dr. Richard Amado, a consultant hired by DHS, and Barbara Takala, the St. Louis County case manager. The review related to Rule 34, but as Mr. Chilberg also stated, it "was conducted as a result of issues identified for class members of Welsch v Levine by Luther Granquist, Attorney for Legal Advocacy." Ex. 54, p. 19. These two documents also corroborate plaintiffs' findings with respect to deficiencies in each area of IHP development and implementation.

9. Dr. Richard Amado, in a memorandum to Warren Bock in which he compared plaintiffs' October 1983 letter with the County's December 1983 response, mentioned above, concluded that there was near total concurrence on the problems at Hearthside although he found some of the County's proposed remedies superficial and unsatisfactory. Ex. 117, pp. 3-5. Based on the material, he concluded among other things that Hearthside should not be licensed as it does "not meet even the minimum standards of rules 34 and 3." Id. at 6. His site visit on February 22,

1984 with Chilberg and Takala confirmed the concerns identified in his memorandum to Warren Bock. Amado Tr. 1/25/85 (AM), p. 118.

10. On July 17 and 18, 1984, Mr. Nord visited Hearthside for the first time and for the dual purpose of determining whether or not licensing deficiencies and Welsch-type deficiencies were being addressed. While no written report was produced on that visit, Mr. Nord testified about his findings which were also summarized in defendants' response to the Notice of Initial Determination of Non-compliance as confirming "plaintiff counsel's charges of deficiencies relating to assessment, goal selection, program implementation, team involvement, program evaluation, and lack of procedures for monitoring psychotropic medications . . . ." Ex. 24, p. 75.

11. Two primary defenses were offered by the defendants -- (1) that improvements are underway at Hearthside (defendants' memorandum, pp. 13-15); and (2) that the class members are better off than they were at MLSH, and as a subcomponent thereof, that they have made some progress.

12. With respect to the first point, they themselves do not deny the continued existence of what are conceded to be numerous or serious deficiencies. See Ex. 59. Thus, in their October 1984 Response to the Notice when defendants maintained that progress was underway, they acknowledged Mr. Nord's frank conclusions confirming the deficiencies based on his July visit.

13. Similarly, while defendants' post hearing findings continue a similar refrain of improvement, relying heavily on and

citing portions of Mr. Nord's testimony (e.g., defendants' findings 25-28), DHS' own February 22, 1985 licensing letter confirms that major deficiencies remain at Hearthside. While the licensing letter addresses the facility as a whole, according to Mr. Nord, the following deficiencies applied to the three class members:

-- Resident programs as set forth in the IPP's were not always being implemented on a regular and frequent enough basis to promote the training objectives with the programs (Ex. 59, p. 2);

-- [lack of sufficiently] individualized [programs] . . . to promote optimal growth and development of the Hearthside residents, [as] [p]rograms contained similar objectives, strategies and criteria for change/termination (Id. at 2-3);

-- At times, areas identified as high priorities in the client's individual program plan were not addressed; there was no corresponding documentation as to why identified needs were not addressed (Id. at 3);

-- A failure to determine and document the need for residents to continue to reside at Hearthside (Nord, Tr. 3/15/85, p. 274-275);

-- Deficiencies in ascertaining the frequency and severity of maladaptive behaviors of persons who are on psychotropic medication and then developing alternative positive strategies to reduce these behaviors (Ex. 59 at p. 3-4);

-- Deficiencies in the manner and use of data collection which is used to ascertain the effectiveness of programming and client progress, raising questions about the data's validity and reliability (Id at p. 4-5);

-- Changes in resident programming without input from the resident's interdisciplinary team (Id. at 5);

-- Need for further staff training as a means to address deficiencies in data collection and practices (Id. at 5);

-- The QMRP (Qualified Mental Retardation Professional) lacked training in mental retardation programming and leadership (Id. at p. 8).

Nord Tr. 3/15/85, pp. 273-279; Ex. 59.

14. As found below (subparts B-F), the testimony and record as a whole also confirm that whatever progress has been made, it has not been significant.[25] Improvement has not been sufficient so as to be reasonably assured that class members' needs are now being met, or will be soon. Future prospects are speculative particularly because of the failure to remedy issues such as staffing and program supervision (see Part IV, infra). Accordingly, relief and further scrutiny continues to be necessary. See Welsch v. Likins, supra, Memorandum Findings . . . (October 1, 1974), p. 33; Welsch v. Likins, No. 4-72 Civ. 451, Findings of Fact, Conclusions of Law and Order for Judgment (April 15, 1976), p. 2.

15. The defendants' second argument, on which they predicate many of their proposed factual findings, that the three class members are "better off", has largely been adjudged irrelevant. It cannot be substituted for a determination as to whether or not an IHP has been properly developed and implemented so as to ensure that the individual needs of class members have been appropriately met.[26]

16. However, one element of the defendants' "better off" standard may be deemed relevant; namely, whether a resident has made progress. Defendants' memorandum, p. 8. That is, progress in skill development and independence is clearly relevant to a determination as to the success of an IHP and program. However it cannot be considered determinative, a point persuasively made by the HHS Appeals Board in the Connecticut proceeding.

> We agree that, where the State has demonstrated that an individual progressed in habilitation skills, the progress may support a finding of

> active treatment. But we do not consider progress by itself to be determinative. In many instances where a client made some progress in meeting one or more habilitation goals, the record also shows that this progress was made despite an STS [Southbury Training School] failure to provide programming with any regularity, or that the client later regressed when a program was terminated due to a staff vacancy, or that the client reached a plateau which could not be exceeded until other services were provided to address a specialized need. Thus, we would be remiss if we viewed the client's progress in isolation without considering whether there is any clear indication that the client could have made significantly more progress if it were not for deficiencies in the STS program design or implementation.

Appendix E, p. 585.

17. Moreover, just as it is essential for clinical reasons to reliably and validly document client progress, this is the case for evidentiary or legal reasons as well. If progress is to be demonstrated for both habilitative and legal reasons, reliable and valid information and data must be presented as opposed to reconstructed subjective and anecdotal accounts of staff whose very performance is being subject to scrutiny. (As found below in Part III(F), Hearthside's data system is in a very poor state.) This issue was also addressed in the Connecticut proceeding.

> The State said that the Board should rely on the oral testimony of the direct care staff, which filled in, amplified, and supplemented the basic written records available for each client. The State said that these witnesses were not impeached, nor even fully cross-examined. As explained below, we found some instances, however, where the witnesses' testimony was contradicted by the written record. More important overall, although we found the witnesses' testimony generally reliable regarding the clients' characteristics and some of the programs planned for the clients, for the most part the testimony was too vague and general to support a finding that STS implemented the programs on any regular basis. Most important,

> in view of the role that documentation must plan in active treatment, the witnesses' testimony is simply an unacceptable substitute for adequate written records.

Id. at 587-588.

18. While anecdotal reconstruction of witnesses should not be totally discounted, as this proceeding demonstrates, without reliable documentation a party would have a difficult burden to overcome. The testimony of witnesses from Hearthside which the Department relied on in their findings regarding progress, was either not backed up with reliable documentation or what data or records existed tended to be confusing or at times inconsistent with the witnesses' testimony.

19. The following examples are illustrative accounts. Citing testimony of Ebacher, Jungwirth and Thoreson, defendants' proposed finding 102 states in part: "Mark's maladaptive behaviors have decreased since he went to Hearthside." With the exception of Ms. Jungwirth's testimony, the sources cited do not address this point. At the time Mark came to Hearthside and up to approximately November 1984, Ms. Jungwirth was the Qualified Mental Retardation Professional (QMRP) at Hearthside. While the defendants did not submit documentation as to what Mark's behavior was like just prior to his coming to Hearthside, the passage from Ms. Jungwirth's testimony cited by the defendants states that Mark had "severe behavioral problems" when he first came and has made "[l]ots of progress" since. Jungwirth Tr. 12/20/84 (AM), p. 201. She further stated that when he first came from MLSH he in fact had about four aggressive incidences per month. Id. at 202. While "hard data" also does not exist as

to what Mark's behavior was precisely like when he first came to Hearthside, there were reasonably contemporaneous written anecdotal statements from Mark's case manager, Delores Rogich, concerning Mark's behavior which she made during her 60-day evaluation of Mark's placement. As her May 30, 1983 evaluation states: "At Hearthside he has adjusted well,[27] interacts with other residents and has had a few minor aggressive and self abuse [sic] which he was easily talked out of." Ex. 103, p. 4. See also Id. at 3 in which Ms. Rogich, also as part of her 60-day evaluation, indicated that Mark's aggressive incidences did not exceed one per month. Thus the situation at Hearthside may have been different from what Ms. Jungwirth recalled during her testimony approximately two years later.

20. More recent records on Mark reveal an individual who is having serious problems with his behaviors. In fact, when Ms. Jungwirth was questioned as to how he was doing now, her response was: "His last incident was in November. He had one incident in November -- two incidents in November, one in October, one in September." Jungwirth Tr. 12/20/84 (AM), p.202. This report is more contemporaneous in time than her recount of his initial period at Hearthside, and the records do accurately reflect the number of incidents. However, in viewing how Mark is doing with his "his frustration level" (Id.), it is perhaps worth recounting the nature of those incidents.

> 9-6-84 Mark came off of the bus very agitated. He was refused coffee because of his behavior of screaming. He threw his clipboard, ran upstairs followed by staff. He kicked a staff person ran outside to his building and proceed to destroy his bedroom. He threw his shoes in the rain. He calmed down after 45 minutes. Was made to retore

[sic] order in his room and when this was accomplished he received coffee and was appropriate the rest of the day. J Jungwirth R.N.

Oct. 12. 1984 - Mark has been very appropriate for the past six weeks. There have been no incidents of agression [sic] or screaming, occasional SIB. His tolerance level seems to have increased. He has been using his board consistently and has been in compliance with most programs. J Jungwirth R.N.

Oct. 27, 1984 Mark was very upset about something tonight. Came screaming over to the Men's house - hit Danny S. over the head many times - pulled the fire extinguisher off the wall - broke the mirror in Peter's room - threw things off Peter's dresser & his own - also threw up in the [sic] his room & the living room. Calmed down shortly after. Karen Wellander.

11/11/84 Mark became very upset this afternoon after bingo. Mark threw the vacum [sic] cleaner around and struck the direct care staff in men's house. [signature illegible] Direct Care

11/22 Mark was screaming and hitting himself, he also hit Dorothy . . . on the back this morning. Joan Abrahamson Day Care.

Ex. 103, pp. 160-161. If one takes the records at face value, (comparing Rogich's evaluations with current records), there may be some evidence of regression, at least with respect to maladaptive behaviors. While that likely or hopefully is not the case, the lack of hard data coupled with varying degrees of inconsistencies, makes it difficult at best to arrive at a finding of progress. See also Part III(F) with respect to general deficiencies in data collection and record keeping at Hearthside.

21. In testimony, again by Ms. Jungwirth as well as Mr. Thoreson, given on 12/20/84 and 3/15/85, respectively, they state that, among other things, Delores' aggressive and other inappropriate behaviors have improved since her arrival at Hearthside. See defendants' proposed finding 138. The testimony by Ms.

Jungwirth, on which the defendants rely, was given approximately three months after Delores was placed at Hearthside. Three inconsistencies are apparent.

22. The first is between what the defendants' proposed finding seems to indicate and what in fact was the case. While proposed finding 138 states that Delores' behaviors have improved since her arrival, the record shows that during the first one to two weeks after her arrival her behavior was generally good, at least according to Ms. Jungwirth on whom the defendants rely for the statement that Delores has improved. Jungwirth Tr. 12/20/84 (AM), p. 206.

23. Second, what Ms. Jungwirth did say does not seem to dovetail with the record either. She testified that Delores, after what she characterized as the "honeymoon was over", did become "aggressive toward other residents" (Id.), but that her behavior has improved since then which she based on her "direct observation" as opposed to data (Id. at 182). However, while the records reveal that indeed Delores did begin having problems approximately ten days to two weeks into her stay, they indicate, at best, a mixed picture since then. In comparing the two-week period of 9/19 to 10/3/84 with the last two-week period for which records were introduced (11/27 to 12/10/84) (which was ten days before Ms. Jungwirth testified), six aggressive incidents occurred during the latter period while five occurred during the former. Ex. 101, pp. 41, 43-44. During the latter period the incidents seem somewhat more severe. Id. and Id. at 45-46. Unless Delores showed meaningful improvement after this last period, i.e., the ten days prior to the commencement of the

hearing (for which the defendants did not produce any records), the quality or amount of progress appears minimal, if it occurred at all.

24. Third, a comparison of the data for Delores' first three months at Hearthside (9/19/84 to 12/10/84) with the three months at MLSH immediately proceeding her placement at Hearthside demonstrates that the frequency of her aggressive behavior has actually increased and somewhat significantly while at Hearthside. Compare Hearthside's data sheets, pp. 41-44 (in Ex. 101) covering the said period of 9/19 to 12/19 with MLSH's "graphic record", pp. 205-208 (in Ex. 101) covering a period of 6/1 to 9/30/84.

25. Defendants also rely on the testimony of Mr. Thoreson who is Ms. Jungwirth's successor as program director at Hearthside. He also indicated in March 1985 when he testified that she had made progress. Unfortunately, the defendants did not supplement plaintiffs' exhibit with Hearthside's records beyond December 10, 1984, against which Mr. Thoreson's testimony could have been measured.

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26. In summary, while there has likely been progress in some areas and Hearthside offers a better environment for these three class members than MLSH, it does not translate into finding that their individual needs have been met because (1) sufficiently hard or objective evidence was not presented by defendants to demonstrate that fact, (2) the defendants' findings as well as statements by the witnesses on which they rely tend to either be unsubstantiated or overstate the extent to which

progress has occurred, and (3) in any event, as mentioned above, it is no substitute for assuring that the components of individualized planning and programming are developed and implemented.

B. Assessment

1. There was agreement that Hearthside was deficient in performing adequate assessments of class members' needs. As with most of the other areas, it was acknowledged only after plaintiffs' investigation but acknowledged it was, by St. Louis County (Ex. 8, pp. 27, 29, 31), DHS Licensing Division and specifically its residential consultant Robert Chilberg in February 1984, along with county case manager supervisor Barbara Takala and Dr. Amado (Ex. 53, p. 15; Ex. 54, p. 19), and in the Departments' formal response to the Court Monitor's Notice in October 1984 (Ex. 24, p.4).

2. Nevertheless, relying substantially on the testimony of Mr. Nord who visited Hearthside in July and November, 1984, the defendants argue that improvement in the assessment process was occurring. Defendants' proposed findings 77-82. They contend this despite the fact that in February 1985, the Department issued a licensing letter citing Hearthside for violating provisions of Rule 34 on assessment. Ex. 59, pp. 2-3. Additionally, it appears, as plaintiffs point out, that there was not an adequate basis for some of Mr. Nord's conclusions that improvements had occurred in this area. Plaintiffs' proposed findings 5.2, 5.3-5.12, 5.31. See also 5.22-5.24, 5.34-5.37.

3. Indeed, precisely during the time period July through December, 1984, when these improvements were apparently taking

place, the record reveals the following continuing, and in some cases, new problems:

a. Team members, including the purported chair of the meeting, the case manager, was not furnished with vital information, such as progress reports and professional assessments, in order to properly prepare for and then contribute to the annual interdisciplinary meeting when the IHP was formulated/revised. Plaintiffs' proposed findings 5.25-5.27.

b. While the standardized instrument, one important component of the assessment process, was fully completed on Delores, the chair of her team, the case manager, did not know that it had been done, raising a question as to whether or not the results were adequately considered. Plaintiffs' proposed findings 5.27.

c. Important professional evaluations in such areas as communication and behavior are still not done or done adequately. Plaintiffs' proposed findings 5.28, 5.22-5.24.

d. There continues to be evidence that important information from standardized assessments or professional evaluations are not adequately considered during the assessment process or by the interdisciplinary team in formulating the IHP. Plaintiffs' proposed findings 5.13-5.14, 5.15-5.21.

e. There was evidence that input from direct care staff, parents, and/or families was lacking because they were not present at the interdisciplinary team meeting. Plaintiffs' proposed findings 5.30.

f. There continues to be a failure to understand the nature and importance of the assessment process which, as

described above, requires the gathering, assessment, and synthesis of factors about a client's needs, strengths, etc. in relationship to current and future environments. See plaintiffs' proposed findings 5.32. For example, rather than proactively and programmatically addressing the problem that Dan has with sexual behavior -- a problem which likely constitutes a major impediment to increased independence and makes him vulnerable to abuse (Ex. 102, pp. 20-22), Hearthside has chosen to rely on "close supervision" (Id. at 22). Jungwirth Tr. 12/20/84 (PM), pp. 145-146. While there was discussion of a "socialization program" (Id.) to address Dan's problems, as of September 1984, one had not been established. Plaintiffs' proposed findings 5.15-5.21. As discussed below, the number and nature of Dan's programs may have diminished since July 1984. As Mr. Johnson put it, the assessment and goal selection process seems to be determined largely or solely by the standardized instrument with no evidence of consideration being given to where the person is going to be in the future, what skills are needed to get there, and what the teaching priorities should be to facilitate it. Johnson Tr. 2/6/85, p. 34. In that regard, Mr. Nord seems to concur. Nord Tr. 3/15/85, pp. 247-248.

C. Goal Selection

1. Deficiencies in goal selection were found by Nord in his July 1984 visit (Ex. 24, p. 75; Nord Tr. 12/21/84 (PM), p. 14) as well as previously by Dr. Amado and Mr. Chilberg in their February 1984 visit (Ex. 53, pp. 15-16; Ex. 54, pp. 19-20).

Problems persist in this area. Plaintiffs proposed findings 5.37, 5.50-5.55.

2. The goal selection process is confusing and not necessarily based on the priority needs as determined during the assessment process. As stated in DHS' licensing letter to Hearthside of February 22, 1985: "At times, areas identified as high priorities in the client's individual program plan were not addressed; there was no corresponding documentation as to why identified needs were not addressed." Ex. 59, p. 3. See also plaintiffs' proposed findings 5.37, 5.50-5.55.

3. A fully constituted team consisting of individuals who may have the most direct and personal knowledge of the class member (e.g., parents, families or direct care staff) were not present during the meetings and therefore not involved in the selection of the goals for the individuals. Plaintiffs' proposed findings 5.30, 5.36.

4. Key members of the class members' team also had different assumptions about sections of Hearthside's IHP format related to goal selection. When Ms. Jungwirth and case managers Forte and Rogich were questioned, they had differing opinions as to what constituted the priority needs of their clients versus long-term or annual goals. Plaintiffs' proposed findings 5.40-5.43.

5. Ms. Jungwirth's version of the goal selection process at Hearthside was the opposite of what it should be. That is, annual goals are recommended by individuals and from that, long-term goals are set.[29] Jungwirth Tr. 12/20/84 (AM), p. 55. It is thus not surprising that critical needs are overlooked; that Dan

can end up with an IHP at Hearthside that consists of three programs consisting of hair combing, military-style bed making on weekends, and a communication program that is carried out 15 minutes per day during the week and 30 minutes per day on weekends at Hearthside. Ex. 102, pp. 32-56.

6. Other indications that goals and programs do not adequately reflect actual assessed clients' needs are that Hearthside has established goals and objectives on skills which have already been mastered (Ex. 54, p. 20), and some of the goals do not appear to be based on the class members' individualized needs because marked similarities exist between the goals of class members. See Nord Tr. 12/21/84 (PM), pp. 14-15.

D. Short-term Objectives

1. Concurring with the initial analysis of plaintiffs, the licensing division in its April 12, 1984 letter to Hearthside stated: "Goals and objectives are not always written in specific, measurable, time-limited manner . . . [e]ach goal and objective should state conditions, target behavior, number of trials and criterion for success." Ex. 54, p. 19.

2. This was based on the specific findings made by Mr. Chilberg and Dr. Amado in their February 1984 visit to Hearthside and which Mr. Chilberg recounted as follows:

> Not all of the objectives we reviewed were complete. Some had parts missing. Objectives need to be observable, to have conditions indicated, criteria of performance stated and time limitations noted. Objective words like consistently, thoroughly, etc. need to be substituted for more measurable terms.
> . . .
> We agree that the goals/objectives are incomplete . . .

Ex. 53, pp. 15-16. See also Ex. 59, pp. 2-3.

3. While defendants claim improvement in this area apparently attributing in part to Hearthside's retention of a part-time consultant and the adoption of a new format (defendants' proposed findings 23, 26), the deficiencies that remain tend to show continued and considerable confusion as to how to develop and implement objectives. Little improvement, if any, was shown in the formulation of objectives. The new format, on which Ms. Jungwirth and Mr. Thoreson received training, was put into use for Mark and Dan in July or August (Ex. 102, pp. 23-56 and Ex. 103, pp. 32-35, 39-42, 44-45, 47-69) and for Delores when she arrived in September 1984 (Ex. 101, pp. 34-74).

4. Numerous and serious internal inconsistencies exist in the way programs are designed for each class member. There are inconsistencies between and among objectives, instructional methods to achieve the objectives, and the data to be collected to measure progress. Plaintiffs' proposed findings 5.60-5.62.

5. Objectives are frequently not stated in specific, measurable and behavioral terms. Plaintiffs' proposed findings 5.61-5.62. They are not often individualized. Ex. 59; plaintiffs' proposed findings 5.63-5.65 and 5.67. As plaintiffs point out: "Eleven of the class members' programs incorporate the same requirement for the level of performance." Plaintiffs' proposed findings 5.68, p. 120.

6. Contrary to professional practice, the timeframe for achievement of the objective is not individualized and objectives are not broken down into intermediate/incremental steps. To the contrary, timeframes for almost all of the class members' objectives appear to be one year, the same as the goals. See, e.g,

Ex. 103, pp. 44, 47, 51, 63; and plaintiffs proposed findings 5.67-5.68.

7. As noted above, goals frequently do not reflect the class members' most important needs; not surprisingly, objectives frequently suffer from the same deficiency. For example, Mark's priority training needs are stated as communication skills, vocational skills, gross motor, functional reading skills and domestic skills. His long-range goals include initiation of "conversations with others on a regular basis" and ability "to make minor purchases independently." Ex. 103, p. 14. While some of his needs and long-range goals are addressed in the habilitation plan at the DAC (Id. at 15-22), the records do not reflect any apparent link up or carry over at Hearthside. Rather, Hearthside's program consists of three grooming programs (use of deodorant, toothbrushing, and bathing), sorting laundry, eating neatly, and use of his communication board. Ex. 103, pp. 32-69. Moreover, Mark's habilitation plan does not address three of the five areas of risk addressed in his abuse-prevention plan; namely, aggression toward others through "a token economy", sexual risk through a sexuality program, and self-abusive behavior (SIB) through a token economy. Id. at 27. While Mr. Thoreson testified on the last hearing day that some changes were made in the objectives, no new program plans were produced to corroborate that fact. Thoreson Tr. 3/15/85, p. 156-157.

E. Teaching or Implementation Strategies/Program Coordination and Comprehensiveness

1. Deficiencies in development and implementation strategies or methods to carry out the objectives is another area on

which there has been general agreement as indicated in the County's December 1983 response (Ex. 8, p. 30), Amado and Chilberg's findings February 1984 (Ex. 53, pp. 15-16; Ex. 54, p. 19), and in the Department's February 1985 licensing letter (Ex. 59, pp. 2-3). Even prior to the commencement of the plaintiffs' inquiry, licensing consultant Chilberg had "recommend[ed] that program plans for the facility indicate in writing the method by which staff will use to work on the goals and objectives with the residents." Ex. 50, p. 2.

2. Up until at least February 1984 it appears that Hearthside, or at least the program supervisor, Ms. Jungwirth, did not understand what "methods" were or at least appreciated their importance. She testified "Mr. Amado . . . also indicated that methods were needed and up until that time I didn't realize what methods meant. So we went ahead and did all the methods that Mr. Chilberg and Mr. Amado suggested and when he and Mr. Nord came up in June, the methods were in place that they had recommended in February." Jungwirth Tr. 12/20/84 (PM), pp. 237-238. See also plaintiffs' findings 5.75-5.77.

3. Referencing changes by consultant Ammerman and based on what the defendants believed were the findings Mr. Nord based on his July and November 1984 visits, the Department's official legal response in this area is that while deficiencies have existed and continue to exist "changes [are] . . . obviously in process" (Ex. 24, p. 75) and "[t]hey have improved in their program implementation, although they do not display a high level of skill" (defendants proposed finding 76, p. 21-22). Of course,

defendants do not conceal the fact and acknowledge continued deficiencies, specifically in the lack of individualization in the formulation of program methodologies at Hearthside (Ex. 59, p. 2-3) and as applied to the three class members (Nord Tr. 3/15/85, p. 274).

4. The evidence shows that Mr. Ammerman introduced a standardized, uniform prompting sequence to be used for many of the programs of the class members which involves the following. The staff was first to give a verbal prompt. If the resident did not respond within 3-5 seconds, the staff was to gesture an approximation of the desired behavior. Again, if there was no response in 3-5 seconds, a physical prompt was to be given. If that did not achieve the required results, the staff was to use hand on hand guidance for the entire step. Ex. 103, p. 39; Jungwirth Tr. 12/20/84 (AM), p. 90, (PM), p. 165. As Ms. Jungwirth noted, this four-step methodology was the method that Mr. Ammerman "gave us that we should use for most of the programs." Id. at 91. Plaintiffs' proposed findings 5.81-5.83. Mr. Thoreson testified in March that this methodology was still being used. Thoreson Tr. 3/15/85, p. 157.

5. Mr. Nord indicated that this method is an improvement; however, he noted it shows a lack of an individualized approach. Plaintiffs' proposed findings 5.85-5.86. Indeed, the use of such a method violates the very principle of individualization which requires the development of teaching methods based on the individualized needs, preferences, interests, and reinforcers as well as deficits of the individual. The evidence establishes that these non-individualized methods were used for approximately five

or six of Mark's current programs (see plaintiffs' proposed findings 5.81 and 5.82), for three of Delores' programs (see plaintiffs' proposed findings 5.83), and possibly for Dan's programs (see plaintiffs' proposed findings 5.82).

6. Where this blanket four-step procedure was not used, instructions given were confusing, unclear and inconsistent (plaintiffs' proposed findings 5.89-5.94, 5.98, 5.103-5.106) and did not provide the kind of clear step-by-step instruction to assure that program is carried out effectively and as intended. Such poorly stated instructions applied to such critical programs as Mark's communication program (plaintiffs' proposed findings 5.103-1.106) as well as Dan's (plaintiffs' proposed findings 5.108). Commenting on Mark's program, Mr. Nord stated that he could not conclude that it was any better than an earlier program. Nord Tr. 1/23/85 (AM), p. 35.

7. Other programs, as Mr. Nord conceded, provided virtually no specific guidance to staff as to how they should be carried out, including programs for Delores' tendencies toward aggressive and other inappropriate behavior as well as her program on fire evacuation. Plaintiffs' proposed findings 5.95-5.97.

8. The record is not adequate to make a definitive determination as to whether or not Hearthside understands and includes procedures to maintain skills once learned. From the face of the three class members' files, it would appear that Hearthside does not. Because of the unacceptable state of the class members' records, or at least those produced at the hearing, it could not

be determined with sufficient certainty whether or not the three class members achieved levels of proficiency so that pure maintenance procedures were warranted.[30]

9. The evidence, circumstantial and direct, indicates that systematic procedures do not exist for ensuring that skills and activities are taught or carried out in an appropriate number or type of environments. At Hearthside, an arguably inordinate emphasis is placed on programs of a self-care nature such as bedmaking and grooming. See Connecticut proceeding, Appendix E, pp. 596-597. Hearthside cannot be faulted for failing to carry out toothbrushing and bedmaking in environments other than the facility itself, but in programs in which it is reasonably clear that the skills and behaviors are applicable to a number of environments (such as communication programs and Mark's coin equivalency program), there is no evidence that generalization procedures are incorporated as part of the program.[31]

10. Hearthside is also deficient with respect to two other requisites which, as discussed in Part II(D)(4), are necessary to ensure that skills become part of an individual's repertoire. First, natural opportunities for learning are not taken advantage of throughout the day as evidenced by the manner in which programs are written (Dan's communication program being limited to one 15 minute session on DAC days and two on non-DAC days), and the lack of activity and program implementation generally. Ex. 59, pp. 2, 7. Second, there is a lack of consistency and coordination of programming between Hearthside and the DAC that class members attend. As one example of this, when Ms. Jungwirth was asked about two of the three programs (out of

approximately seven that Mark has) in which carry-over or cross-over could occur at the DAC he attends (e.g., his coin equivalency program and his table manners program), Ms. Jungwirth was unaware as to whether or not he was on such programs at the DAC. Jungwirth Tr. 12/20/84 (AM), pp. 71, 99. Mr. Thoreson did not know if the DAC, like Hearthside, was baselining Dan's SIB. Plaintiffs' proposed findings 5.129. See also plaintiffs' proposed findings 5.30, 5.31, 5.49.

F. Program Evaluation and Monitoring by Hearthside

1. There was little, if any, disagreement as to the fact that Hearthside was highly deficient in collecting data for program evaluation up through July-September 1984 (plaintiffs' proposed findings 5.110-5.118) and thereafter, as well, when a new format was adopted and new procedures were introduced primarily by Mr. Ammerman (plaintiffs' proposed findings 5.123-5.124). As the Department itself pointed out in its February 1985 licensing letter:

> As of the date of the last review, the recently utilized 'learner performance data sheet' had been utilized for only about 50 percent of the residents.
>
> Where these new data sheets have been used, facility staff have not always filled them out in a uniform manner. This makes obtaining scientifically valid data regarding the resident progress impossible. This can result in improper decisionmaking regarding the implementation of individual treatment plans. Additionally, the data sheets have not been filled out completely. The level of assistance rendered by staff to help the resident accomplish the objective is frequently not recorded. In a few instances differences by two staff persons regarding progress made by a resident on a particular goal have been noted. For example, night staff may indicate that a person is on level 17 with regard

> to a certain objective, while another staff person working afternoons indicates that the same resident is on level 10 regarding the same task. This discrepancy results in questions about the data's validity and reliability. Finally, major changes in resident programming have taken place without input from the resident's interdisciplinary team.

Ex. 59, pp. 4-5 (emphasis added). See also Nord Tr. 3/15/85, p. 277 in which he indicates that the deficiencies in data collection apply to class members.

2. In their proposed findings, defendants state: "Data collection remained weak as of December 1984, but has, according to the interim program director, improved considerably since that time." Defendants' proposed findings 76. The evidence amply supports the first part of the statement and the defendants did not offer either through the interim program director, Mr. Thoreson, when he testified in March or otherwise any additional client records beyond what plaintiffs introduced in December to corroborate Mr. Thoreson's testimony.

3. Defense counsel's other point in their proposed findings does not justify the practices at Hearthside. Citing Mr. Nord, they state: "Hearthside is not the only facility in Minnesota that needs work on data collection." Id.

4. Comparisons with other programs in the state aside, Mr. Nord was not very complimentary about the data collection procedures at Hearthside either before or after the changes were made in July-September 1984. He stated that he "saw deficits in the data collection of all the Welsch clients." Nord Tr. 12/21/84 (PM), p. 46. While he indicated that he had seen improvements, he did not identify any program in which he determined that the data collection procedure process at Hearthside

was acceptable for any of the class members. See plaintiffs' proposed findings 5.124.

5. The data collected after July 1984 was so poorly recorded that it could not reliably be used to determine resident progress, nor is it at all helpful in evaluating what changes should be made in programs or in the manner they are being implemented by staff. As outlined below, none of the requisites were met to assure adequate collection of data and the use thereof in determining resident progress or the effectiveness of programs, as written or carried out.

6. First, while a new format was introduced at Hearthside in the summer of 1984 on which Mr. Thoreson and Ms. Jungwirth received training, the data was not collected in accordance with the procedure required by that format. Plaintiffs' proposed findings 5.119-5.122.[32] While there is nothing sacred about any particular format, nor should there be anything to prohibit justified deviations from or adaptations to it, where Hearthside adopted this format one would hope that there would have been reasonable conformance to it. This did not occur, nor were there any explicable rationales for its misapplication. Mr. Johnson, who is one of the trainers, explained how it was supposed to work. It is found that when used as intended it is clearly understandable and internally coherent. See Johnson Tr. 2/6/85, pp. 37-49.

7. Second, the evidence showed that different staff collected data on the same program differently. Plaintiffs' proposed findings 5.125. In a case involving Dan's hair combing

program, Mr. Ammerman in reviewing data from apparently only one shift, stated "stuck on step four--break it down into component--tighten implementation." Ex. 102, p. 131. Because Mr. Thoreson who apparently reviewed data from another shift on the same program found that Dan completed all the steps, wrote "discontinue--goal completed." Ex. 102 at 133; Thoreson Tr. 12/20/84 (PM), p. 276. These contradictory notations by Mr. Ammerman and Mr. Thoreson were written on the same day, October 25, 1984. Compare p. 131 with 133 in Ex. 102.

8. Third, as in the case of Mark's communication program, data collection was not consistent with the instructions. Plaintiffs' proposed findings 5.138.

9. Fourth, because Mr. Ammerman's instructions with regard to data collection and then the analysis of the raw data were not clear or detailed, unacceptable and unreliable computations and determinations were made about the progress Dan was making on his communication program. Plaintiffs' proposed findings 5.131-5.133.

10. Fifth, because of where client programs and data sheets are kept, information cannot always be recorded at the time or soon after the behavior is observed which, as indicated above, can invite error. Plaintiffs' proposed findings 5.125.

11. Sixth, there is no individualization in the increments for program review. That is, programs are reviewed quarterly across the board and no individualized determination based on the individual program and objective is made as to whether or not a different time interval is appropriate. Plaintiffs' proposed findings 5.140-5.141. Programs such as Delores' bathing

program and baselining of Dan's self-injurious behavior were continued long after their termination date indicating modifications should have been made. Plaintiffs' proposed findings 5.126-5.130. See also plaintiffs' proposed findings 5.141.

12. Seventh, there is not adequate staff training and monitoring of staff performance to assure that staff understand what they are doing. Plaintiffs' proposed findings 5.138-5.139. See also Ex. 59, p. 6. The new format has not made data collection and evaluation more viable at Hearthside. If anything, because of the lack of understanding and training as to how to perform this important function, the recent data collected may be even less helpful than prior to the adoption of the new format. The Department's own licensing letter states adequate staff training is needed for both direct-care staff and the program supervisor(s). Ex. 59, p. 6. It would appear based on the way in which data is collected that such training needs to stress the role and purpose of data collection and evaluation as well as, of course, the actual techniques and mechanisms.

G. Conclusions; Additional Findings

1. The following Findings are conclusory, and are based on or complement the discrete Findings relative to each component of the IHP process at Hearthside contained in Sections A-F, above.

2. First, the problems described in the assessment and interdisciplinary team process have a negative impact on the overall development of the IHP for each class member. In particular, they affect the goal selection as well as development of

the "implementation methods". These procedures should result in a selection of goals and design of programs which assist the individual to acquire more functional skills and to replace inappropriate behaviors so that his or her independence and participation in current and future environments can be facilitated or enhanced. At Hearthside, the process is, for the most part, not sequential and is based largely and rather myopically on deficits which show up in a standardized instrument.

3. Second, another indication of the incomplete or inadequate assessment process is the use of the same training methods or implementation strategies for each class member. This fact alone is antithetical to the need and importance of assessing for individual interests, preferences, reinforcers, etc. In fact, the overwhelming evidence, as summarized in sections B and E, indicates that the assessment process is not effectively used in helping to define effective implementation methods or strategies. The lack of individualization pervades other areas as well, including goal selection and objective formulation.

4. Third, in applying the criteria for an adequate IHP to each of the class member's programs at Hearthside, not one passes muster. Nearly every component of each IHP of each class member suffers from deficiencies to one degree or another in goal selection, objective setting, implementation methods, data collection, and program evaluation. While some improvement was discerned in some areas, in general it was negligible or non-existent. For the most part, the deficiencies were not disputed.

5. Fourth, as found and discussed particularly in Part II(D)(4), supra, it is important to assure that programs,

activities, and learning experiences are not limited to formal program times (e.g., at the DAC or in 15-minute sessions), but are carried on throughout the day and in various environments, as appropriate. This principle is important not only from a learning and habilitative perspective, but in order to provide an enriching experience and quality of life which the defendants stress as an overriding consideration in determining the appropriateness of placement. Unfortunately even on this count because of problems in IHP development Hearthside is lacking. While the overall situation may be better for the three class members than their previous experiences at MLSH, there were characteristics even at Hearthside confirmed on the Monitor's view (see Welsch v. Likins, supra, Memorandum Findings . . . (October 1, 1974), p. 22), and not disputed, which put Hearthside at somewhat of a disadvantage relative to smaller programs or ones located nearer to or within municipalities. See defendants' proposed finding 14; Hearthside's Counsel's April 16, 1985 letter and proposed findings, p. 2. Hearthside is a large facility with a capacity of 40 residents, is in a remote and somewhat isolated location, and because of lack of public transportation is a somewhat restrictive environment. See Developmental Disabilities Program. Policy Analysis Series #4: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICF-MR) Per Diems. St. Paul, MN: DD Program, Dept. of Energy, Planning and Development (September 1981), pp. 24-25 and citations therein. While, as defendants point out, it is in an attractive location, and each building has a more or less home-

like appearance, institutional-like qualities exist.[33] It is located a little over two miles from a main highway and about five miles from Tower which is a small town and as such, does not offer a high number or variety of work or leisure opportunities for Hearthside's residents, to include the class members. There is, of course, no public transportation in the area, and residents have to rely on staff for transportation to and from Tower, or to larger towns which are located considerable distances from Hearthside. Virginia is approximately 30 miles away. Thoreson Tr. 3/15/85, p. 161; see also defendants' proposed finding 14.

6. The problems in the IHP process compound rather than neutralize or offset these characteristics by (1) providing for only a narrow range of programs and limiting the occasions and opportunities in which they may be formally and informally carried out at Hearthside (see section E above, generally; see also Johnson Tr. 2/6/85, pp. 61-64; Forte Tr. 1/11/85 (AM), pp. 164-166; section D, Findings 5-7; section E, Findings 10-11 and footnote 31, supra; Ex. 59, p. 7)[34], (2) lack of programs designed to instruct residents (class members) to initiate leisure and recreational skills on their own, and (3) lack of procedures to ensure generalization of skills in natural community environments. See section E above.

7. A rural lifestyle, by its nature, may not offer the breadth of opportunities that a less rural setting does (see defendants' findings 14); however, that does not justify an unduly limited opportunity for habilitation, activity, and stimulation. There are, as suggested, some benefits to Hearthside

because of its setting. See Schalock, R. L. (Ed.), Monograph No. 2--MR/DD Services in Rural America . . . It is Time, Institute for Comprehensive Planning, 1979, I(2), p. 123.

8. In short, characteristics about Hearthside and its environs provide advantages and disadvantages to the provision of habilitation. The requirements of the Decree apply equally to all class members; if disadvantages to a placement may prevent or impede the realization of the requirements, then either the placement should not occur or the drawbacks need to be neutralized or offset. Not coincidentally, the starting and central point is a properly developed IHP and the resources, staffing and otherwise, to carry it out.

9. The purpose and function of an IHP may be more important in a rural area; it can also be used to take advantage of the unique opportunities in a rural setting. As summed up by Schalock:

> Rural service delivery programs for the developmentally disabled face unique problems related to financial resources, transportation, limited professional generic staff, availability of trained personnel, limited existing facilities, and a sparce and usually scattered population. These problems, combined with a fictionalized caricature of what 'rural' really represents, can create a substantial barrier to the development of service delivery systems. However, it has been the experience of the authors contributing to this Rural Monograph that the above mentioned problem associated with rural settings can be overcome if a community is sufficiently aggressive in their pursuit of a rural service delivery program.
>
> In that regard, if comprehensive rural services are to be provided to the developmentally disabled, planning and program development must be built upon rural resources and positive characteristics such as folk support systems (Ginsberg, 1969; Wylie, 1973), pride and community spirit (Horejsi, 1977), geographical proximity to decision makers (Mayeda,

> 1971), family stability (Rogers & Burdge, 1972), acceptance of the developmentally disabled (Berkeley, 1976), and rural employment opportunities (Conley, 1973).

Id. at iii.

10. In short, the nature, size, and location of Hearthside makes the importance of IHP planning and programming particularly important. Unfortunately, the failures in this area merely serve to compound rather than enhance the situation for Dan, Delores, and Mark.

IV. FINDINGS WITH RESPECT TO STAFFING

A. Importance of Sufficient Numbers of Adequately Trained and Supervised Staff

1. Human services is a labor intensive field. It is well recognized in legal, professional, and the regulatory fields that the issue of adequate programming in human services is inseparable from adequate staffing. As the Court stated in 1974, provision of adequate habilitation requires "qualified staff personnel in sufficient numbers." Welsch v. Likins, supra, Memorandum Findings (October 1974), p. 11. See also Welsch v. Likins, supra, Findings (April 15, 1976), p. 14; DPW Quality Assurance Plan for State Facilities, Court Monitor's Ex. G, p. 15.

2. The need to assure that personnel have sufficient skills and knowledge to provide services, including implementation of complex programs, is applicable to community-based programs regardless of size or location. Schalock, pp. 115-116; ICF/MR regulations and Interpretive Guidelines, Appendix D, p. 416. In an ICF/MR, for example, small or large, community-based or institutional, residents are by definition "deficient in skills across . . . [a] spectrum of development to one degree or another." Id.

> Thus, socially, emotionally, cognitively, physically, and communicatively, the resident can benefit from staff who can interact with him or her both formally and informally in a way which supports the goals and objectives of the individual plan of care. This implies that the staff is adequately trained to carry out programs designed by the interdisciplinary team. One can readily envision, for example, staff implementing a behavior shaping program designed to teach a resident how to use leisure time productively rather than allowing the resident to come home and stare at a television set; or the staff members may carry through with a specific portion of a language

> program in the facility by the way in which they structure their communications with the resident and the way they structure his language production as well. Certainly, the staff would be expected to keep accurate performance data as a part of an effective intervention program.

Id. See also Wray Tr. 12/21/84 (AM), pp. 32, 34.

3. Pre-service and in-service training and supervision on the job, are important in the mental retardation area. Supervision is necessary to ensure that competencies developed during training are applied properly on the job, specifically to individual client programs. Adequate training and supervision seem to be particularly important in this field for at least three reasons.

4. First, many persons assume direct care and paraprofessional positions (and as seen in this proceeding, supervisory or professional positions) with little or no formal training or qualifications in the area. Schalock, p. 19; Governor's Planning Council on Developmental Disabilities, Policy Analysis Series Paper No. 12: Analysis of Nonformal Training for Personnel Working in the Field of Developmental Disabilities in Minnesota: 1981-1982, St. Paul, MN (January 1983), p. 5.[35]

5. Second, professionals who come into this field frequently come from different backgrounds with different approaches, views, and perceptions (Id. at 3) resulting in, among other things, professional turf problems. Court Monitor's Ex. A, p. 5.

6. Third, advances in the field have been occurring rapidly over the past twenty years as the perceptions of persons with mental retardation have changed, particularly of those who

have severe or multiple handicaps like the majority of Welsch class members. Adequate staff training is therefore essential. See Welsch v. Likins, supra, Findings (April 15, 1976), pp. 12, 14. As stated by the Governor's Planning Council (January 1983):

> As the field of developmental disabilities receives more attention and clients are provided with the opportunity to become more involved in the community, a concerned and committed staff may not be sufficient. It is also critical that staff members possess a basic body of knowledge concerning the causes and effects of disabilities and the training and motivation of clients. This body of knowledge has been greatly expanded by recently published information; a knowledge base that was considered adequate a decade ago may not currently provide staff with skills they need to be effective. It is likely that this body of knowledge will continue to expand in the future

Policy Analysis Series Paper No. 13, p. 2 (emphasis added).

7. It has been strongly maintained that training cannot be fragmented and piecemeal by relying on sporadic workshops or in-services, but rather must be proactive, planned, and sequenced to current technology and what the program is attempting to accomplish. Id. at 2, 4. The Department itself emphasized this point in the Minnesota Model Standards (Court Monitor's Ex. A) in calling for systematic, proactive and regionalized training throughout the state; this, as opposed to a piecemeal, "facility-by-facility approach." Id. at 4. Unfortunately, at least for Hearthside, they have not benefited from either approach, as little training -- piecemeal or otherwise -- has been provided to their staff. In addition to pre-in-service programs for new and existing employees, discrete staff training around individual programs is frequently necessary to ensure proper development and implementation of teaching strategies or data collection.

Johnson Tr. 2/6/84, pp. 80-82; Wray Tr. 12/20/84 (AM), pp. 32-34. See also Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 120.

8. As in all fields of endeavor, personnel should not be left on their own after training. To ensure that new procedures are carried out, supervision, including "demonstrations, practice, and feedback" is necessary. Paine, Bellamy, and Wilcox (Eds.), Human Services That Work. Baltimore: Brookes Publishing Co., p. 237.

9. Thus, qualified supervisory and professional staff are needed; in an ICF/MR one such person is the Qualified Mental Retardation Professional (QMRP). 42 CFR 444.411, Appendix D, p. 45. At Hearthside, this person was called the "program coordinator and up until December 1984, it was Jan Jungwirth, R.N., followed by Kyle Thoreson who was designated as interim program director.

B. Staffing Inadequacies at Hearthside

1. Plaintiffs, in their October 1983 report, raised staffing issues both with regard to Hearthside's capacity to provide adequate habilitative programming and residents' safekeeping at night. Ex. 1, pp. 3-4. After plaintiffs' visit to Hearthside, two additional night staff were hired so that coverage could be provided in each building (Abrahamson Tr. 3/15/85, pp. 84-86); however, no other staff were added to help address program inadequacies. See Id. at 88-91.

2. The County acknowledged in December that there was a shortage of staff during the afternoon shift (Ex. 8, p. 8) and

the Department, based upon Mr. Chilberg's and Dr. Amado's February 1984 visit, also cited shortages in staff during the early morning hours and throughout the entire second shift. Ex. 53, p. 17; Ex. 54, pp. 20-21. Mr. Nord and Mr. Chilberg, based on their summer and late fall visits of 1984, testified that the problem of staff shortages had not been addressed. Nord Tr. 1/23/85 (AM), p. 51; Chilberg Tr. 1/25/85 (AM), p. 68 and (PM) pp. 46, 51. The Department officially confirmed this in their February 1985 licensing letter (Ex. 59), in which deficiencies were cited in numbers of staff (p. 7), as well as staff training (pp. 5-6) and qualifications of the program supervisor (p. 8).

3. Mr. Abrahamson testified that he had 12 to 14 full-time equivalent staff for 40 residents for all shifts; this included direct-care staff as well as an activity person, a program coordinator, and the nurse. Abrahamson Tr. 3/15/85, pp. 97-107, 114-115. Mary Kudla determined that the ratio of program staff (including direct care, program coordinator, nurse, activity person) to residents was approximately 1 to 11 during peak program hours and, at times, as high as 1 to 14.[36] Kudla letter to Abrahamson, May 3, 1985, Dept. Ex. 14, pp. 2-3.

4. Ms. Kudla's analysis, which was merely based on a paper review of the schedules (Dept. Ex. 14, p. 1), did not analyze to what extent, if at all, direct care staff are diverted to non-program or non-client-oriented duties such as housekeeping. Some of the staff serve dual capacities (e.g., cook also being involved in part-time direct care). Abrahamson Tr. 3/15/85, p. 66; Dept. Ex. 14, pp. 2-3; Hearthside response to Kudla letter, July 2, 1985 letter from counsel to Court Monitor,

p. 2. In fact, during the Monitor's visit (see Welsch v. Likins, supra, Memorandum and Findings . . . (October 1, 1974), p. 22) (which apparently was the only on-site review done without advance notice) it was observed that of the several direct-care staff on duty one was folding laundry in the women's building and not involved with residents. It was also learned that two other male staff in the main house and the men's building were involved in bathing male residents although Ms. Jungwirth indicated to the Monitor subsequently that one of the staff had been providing some communication programming to a single resident for a period of time during the visit. While no judgment is being made as to whether or not these afternoon baths were part of the formal programming effort or just pure care-rendering -- and no definitive finding should be made on this issue -- as part of resolving the overall staffing deficiencies at Hearthside attention should be paid to whether direct care staff are having to perform multiple duties, some of which do not directly relate to habilitative programming. Such examination is especially warranted not only because of the acknowledged high staff ratios to begin with, but because of the general lack of activity at Hearthside (Part III (E) and (D) supra) and the financial demands already placed on Hearthside's operation create a situation where staff may be called upon to perform several functions. See Hearthside's counsel's letter to Court Monitor, July 2, 1985, p. 3; Abrahamson Tr. 3/15/85, pp. 84-86; and section C below.

5. Hearthside's direct care staff are paid $4.25 to $5.00 per hour. Abrahamson Tr. 3/15/85, p. 115. Mr. Thoreson, who had

been the recreation therapist, did not receive a change in his salary when he became interim program director and continued to receive $1,000 per month. Id. at 117-118. Pat Banovetz, who was hired during the hearings with the possibility that she would become the co-QMRP with Mr. Thoreson, was hired at $5.00 per hour. Id. As will be discussed below, a lack of funding is a substantial impediment to Hearthside's ability to hire additional staff, pay higher salaries, etc.

6. As to training, the deficiencies in the IHP's are the most tell-tale sign of the need to address this area and to enhance the skills and knowledge of the staff at all levels at Hearthside. The Department's February 1985 licensing letter affirms this very fact: "Inconsistencies in data collection and program implementation noted at Hearthside indicate that further staff training is needed to remedy rule deficiencies." Ex. 59, p. 6. This very point was made to the Department by its consultant, Dr. Amado, in his January 17, 1984 report in clear terms when he indicated the need for intensive in-service training for staff. Ex. 117, p. 7. The need for training was also acknowledged by Mr. Nord (Tr. 1/23/85 (AM), pp. 50-51) and Ms. Jungwirth (Tr. 12/20/84 (AM), pp. 213-214, 223-227). Ms. Jungwirth specifically spoke about the need for regular in-service such as quarterly. Id. at 224.

7. Nevertheless, despite this clear and long-standing need, Ms. Jungwirth was not aware of any technical assistance or in-service training that Hearthside had received from either the county or the state on how to comply with Rule 34 program requirements prior to October 1983 (Id. at 226-227), and she had

been program director at Hearthside from 1977 to 1984. Id. at 27. It was not until June 1984, when she and Mr. Thoreson attended the individual program planning seminar offered by GTS, that training on data collection and methods were received. Id. at 77-78, 170, 227. As Mr. Abrahamson candidly admitted, to live up to plaintiffs' proposed standards (which were conceded to be substantially similar to standards which had been in effect all along (defendants' proposed findings 198), but which were obviously not enforced) that additional training would be necessary including the funds to pay for it. Abrahamson Tr. 3/15/85, pp. 53-54.

8. Finally, it was not disputed that there was a need for a change in the QMRP. Mr. Thoreson was designated interim program director, but the Department has determined that the interim program director "may not meet the eligibility requirements for QMRP . . . [and that] he lacks training in MR programming and experience in a leadership position." Department's February 22, 1985 licensing letter, Ex. 59, p. 8. When Mr. Abrahamson testified in March, this issue had not been resolved and he was entertaining the possibility of proposing that Mr. Thoreson and Ms. Banovetz, who was newly hired, act as co-QMRP. Abrahamson Tr. 3/15/85, p. 32. Based on the record of the proceeding, it must be concluded that Hearthside continues to be deficient in providing supervision to direct care/paraprofessional staff necessary to assure that the class members' needs are appropriately met.

C. Effect of Low Per Diem and Rate Increase Cap

1. If the class members are to remain at Hearthside, one alternative is to concentrate existing staff more heavily on their program needs. Obviously, this would not be acceptable as other clients would suffer.

2. Thus, the solution would appear to be to increase staff numbers, training, and supervision generally, or in the alternative, add additional staff (and training) for the class members solely and directly.

3. The preponderance of the evidence indicated that to pursue either of these courses additional funds would be necessary (Abrahamson Tr. 3/15/85, p. 43), not only to hire more staff, but to enhance in-service training to the point where staff were capable of meeting clients' needs in light of the requirements of paragraph 24. Id at 53-54.

4. However, because of a five percent rate increase cap imposed on ICF/MR's in 1983 (Mn. Laws 1983, ch. 312, art. 9, sec. 7, subd. 3, Minn. Stat. 256B, 501, subd. 3), Hearthside cannot obtain the increases and funding it needs to increase and enhance staff numbers and training. Id. at 42-43, 53-54; Hearthside's proposed findings 92. This was also the case for the two years prior to 1983 when a ten and then four percent cap were in effect. Plaintiffs' proposed findings 6.22-6.23. Hearthside has had an appeal pending with the Department's Rate Division for well over a year in an attempt to obtain a higher rate, but has been unsuccessful. Abrahamson Tr. 3/15/85, p. 65.

5. This cap, as well as the previous ones, works a special hardship on clients who reside in facilities like

Hearthside that have historically low per diems. The per diem at Hearthside is approximately $40 per day. See Court Monitor's Ex. B, p. 9. Because it is an older ICF/MR facility, having been established in 1974, its rate was initially established and increased based on a relatively higher functioning clientele whose needs were considerably less than individuals who have been placed more recently, such as Delores, Dan, and Mark.

6. Rather than aid these older facilities that are now taking more challenging clients, caps were imposed that placed them in a double bind or "Catch 22". April 16, 1985 cover letter to Hearthside's proposed findings, p. 2. In short, while client demands and concomitant staffing needs increased, the rate structure, in effect, retrogressed. Mr. Abrahamson contrasted this period with the "good old days" which existed apparently prior to 1981 when 15 percent increases were allowable as well as "pass throughs" at a time, ironically, when the needs for such increases may have been less than they are now. Abrahamson Tr. 3/15/85, pp. 20-21; plaintiffs' proposed findings 6.28. As Mr. Abrahamson described:

> After that [after the caps were imposed] it was almost impossible to provide for more staff, and the higher functioning residents were moving into apartments, SILS, wherever we could place them. The lower functioning residents, which now are called Welsch clients, were starting to come out of the state hospitals. There was no provision for transferring or sending along the same rate that they had had in the state hospitals and that made it difficult, if not impossible, to try and increase your program staff without the additional funds.

Id. at 21. He goes on to state: "I have actually done more than I could afford under the per diem, as far as staff goes." Id. at

21-22. This systemic problem was recognized by Ardo Wrobel, the Mental Retardation Division Director, as early as 1982, when commenting on the then 10 percent cap.

> Several programs which have been in operation for over five years with relatively low rates (i.e., less than 35/day) have begun to 'turn over' their populations taking much more difficult clients. They have been finding that their staffing patterns are inadequate to program for many of these difficult residents and, under the cap, are either facing the necessity of closing or returning the residents to the state hospitals. For example, 50% of state hospital admissions are readmissions from ICF/MRs who could not 'handle' the behavior problems with their existing staff.

Court Monitor's Ex. M, p. 5.

7. Unfortunately, since that time, the situation has appeared to have actually grown worse since the cap has been reduced to five percent, and class members being placed are probably more handicapped on the whole. Dr. Bock, when he testified in January 1985, acknowledged that this continued to be a problem. Bock Tr. 1/23/85 (PM), pp. 116-117.

8. Ardo Wrobel's comments were taken from a memorandum he prepared for the Department of Public Welfare Advisory Council on which Commissioner Noot was copied, in which he addressed the per diem cap as one of the "priority areas for 1983-85 legislation." Id. at 1. The record does not reveal precisely what efforts Commissioner Noot or the Department made then to eliminate the cap or address its effects. The record is not much clearer since that point.

9. Dr. Bock testified in January 1985, that he thought the Department was initiating legislative proposals to address this problem. Bock Tr. 1/23/85 (PM), pp. 120. Based upon this

statement, the Monitor requested that defendants' counsel supply the Monitor with a copy of any legislative proposals addressing this rate increase issue. Id. As it turned out, apparently no legislative request was generated or made but defendants' counsel furnished proposed Rule 53, two pages of which were received into evidence as Court Monitor's Ex. O. The proposed provisions in evidence could provide for a one time pass-through adjustment if additional staff are necessary to comply with licensing standards. Court Monitor's Ex. O. It has since been promulgated as the new permanent Rule 53 (parts 9553.0010 to 9553.0080), and changes have been made from the portion of the draft in evidence; therefore the relevant provisions from the final version (pages 44-47) are attached hereto as Appendix F. Whether it would provide relief to Hearthside and the class members therein remains speculative, particularly in light of the impasse between the Department and Hearthside over whether new staffing is needed or existing staff can be reallocated. See Appendix F, Subp. 3(A)(2), p. 755. Compare Dept. Ex. 14 with Hearthside's counsel's 7/2/85 letter to Court Monitor and Court Monitor's Ex. S; see also plaintiffs' counsel's 7/8/85 letter to Court Monitor.

10. As mentioned above, another option could be to add additional staff directly assigned to class members. DHS Rule 186 allows an increase in a facility's rate for a limited period of time to meet special needs of a particular resident or residents. Bock Tr. 1/23/85 (PM), pp. 129-130, 132-134. A copy of the rule, which was effective October 26, 1984 was received into evidence as Ex. 87.

11. When Mr. Abrahamson testified in March, he indicated that he had received a copy of a Rule 186 application just one month previously from case manager supervisor Takala and intended to complete it shortly after the completion of the hearings on March 15, 1985. The record, therefore, does not reflect whether or not the application was made, and if it was, what disposition was made of it by the Department.

12. In conclusion, an adequate number of trained direct care, professional supervisory staff are necessary to ensure that class members' needs are appropriately met, and specifically to ensure that IHP's are adequately developed and implemented. It is the Commissioner's obligation to see to it that persons and entities under his supervision or control understand and ensure that this standard is met during the discharge process as well as after placement. The evidence demonstrated that because of the cap(s) there are other facilities which currently house class members that have lower per diems and therefore are not or may not be appropriately meeting the needs of class members. See Part V(F), infra. As to the spectre of placements from state hospitals to low per diem facilities in the future, increased funding may be necessary, or in the alternative, placements should be diverted elsewhere to programs which do have adequate staffing so that there is a reasonable assurance that the needs of each and every class member will be met.

V. OTHER FACTORS AFFECTING THE CLASS MEMBERS' PLACEMENT

A. Introduction

1. The Findings in Parts III and IV have focused primarily, although not exclusively, on matters internal to Hearthside. Inseparable from and indeed part of the discharge process and the quality of the IHP and placement itself, are the procedures, operations, and actions of state hospital, county case management, licensing and the Department's central office.

2. Two somewhat interrelated aspects of the central office's action are at issue: (1) its efforts, generally, to ensure the proper operation of these other components of the service delivery infrastructure so that there was and is a reasonable assurance that class members placed in the community, including Delores, Dan, and Mark, have or will receive services in accordance with paragraph 24; and (2) the Department's actions once they were apprised of and/or acknowledged the deficiencies in the three class members' programs at Hearthside. This latter issue is addressed in Part VI, infra.

3. The record shows that inadequacies in the discharge process, case management, and licensing have contributed to the lack of adequate IHP development and implementation for class members. The preponderance of the evidence further indicates that unless corrective measures are taken on these fronts, the needed improvements to the class members' programs will not be adequately made. Those measures must include clear direction from the Department as to what is required from these units of government and personnel so that class members' individual needs are appropriately met. This can be accomplished either through

revision and/or clarification of existing standards and rules or the issuance of new ones, but in either case, there must be corresponding enforcement.

4. Defendants, during the course of the proceeding, challenged the relevancy of these issues, and in their memorandum, have raised a number of legal arguments against the issuance of recommendations in these areas. Thus, the legal basis for the inquiry will be discussed before examining the evidence.

B. Relevancy of Issues

1. Defendants primarily contend that consideration of and recommendations related to issues of case management, licensing, and system-wide standards are beyond the scope of the Decree. Defendants' memorandum, pp. 28-33, 36-45.

2. However, there is nothing in the Decree which may be read to restrict issues or paragraph 95(g) recommendations to what the status quo was in 1980 or within some other narrow construct. To the contrary, the plain language of the Decree and the intent of paragraph 95 (d)-(g), authorizes and indeed obligates the Monitor (or hearing officer) to make "findings of fact based upon the record presented at this hearing together with whatever recommendation regarding corrective action . . . [he] may deem appropriate." Paragraph 95(g) (emphasis added).

3. Findings must be based on the record of the hearing, and since the term "appropriate" is not further defined in this provision either, given the context, it is clear that the recommendations must also be based on the record as well as principles of federalism (defendants' memorandum, p. 19) balanced

against the posture of the case and the rights at stake. (See Part I(A)(7), supra).

4. The oral and documentary evidence addressed not only the inadequacies in the class members' habilitation plans and programs, but appropriately and justifiably the factors causing or contributing to or preventing their adequate address. In other words, what went wrong and why have been examined, and the findings and recommendations herein are based on the record of that examination. Part I(A)(10), supra.

5. The defendants cite no provision which limits this process. Rather, they rely primarily on what they believe is a paucity of substantive provisions in the Decree, which thus precludes what they say is system reform of case management and private facilities beyond what was required or contemplated in 1980. As stated above, paragraph 95(g) alone, undercuts this argument. As discussed with respect to the requirements of paragraph 24 (Part III(B)), the Decree as a whole as well as allied provisions belies defendants' position. If anything, the Decree envisioned a change in status quo, and in any event did not restrict it if changes were necessary to assure compliance. An examination reveals no provision which restricts, as a matter of legal construction, the recommendations which may be made in a non-compliance proceeding.

Status Quo Argument

6. Defendants state in their Memorandum:

> It is evident from the brevity of the reference and from the use of a term such as 'appropriate' in drafting the Decree that the standards to be applied in determining 'appropriateness' of

> community placements received little attention. The Consent Decree is explicit where the defendants were required to change the status quo. As it is not explicit in paragraph 24, the parties apparently contemplated no change. Therefore, none can be required now.

Id. at 22-23. See also p. 36. The defendants do discuss some of the other community provisions in the Decree but ascribe minimal significance to them. See, e.g., Id. 36-45.

7. As is not atypical in these documents, the parties did not delineate findings of fact or deficiencies. Instead the Decree contains the following express language: "The provisions of this Decree shall not constitute an admission by the defendants as to the truthfulness of any of the allegations in the Complaint or as to their liability in this action." Paragraph 110. The lack of explicit findings applies both to the state hospital and the community side of the Decree. As with any issue of construction, defendants' argument must be examined in light of the provisions that do exist within the four corners of the Decree as well as relevant aids of construction (e.g., context and circumstances surrounding negotiation and formulation) so that conjecture is not engaged in and the true intent of the parties can be ascertained (ITT Continental, supra 420 U.S. at 238-243) as opposed to a construction which "might [now] satisfy the purposes of one of the parties to it." United States v. Armour & Co., supra 402 U.S. at 682.

8. This task is not accomplished by evaluating the number and level of detail of paragraphs relating to one part of the Decree. Examples are infinite in jurisprudence, philosophy, and religion that demonstrate that a few words, phrases, or sentences

in a writing can obviously have far reaching impact, more so than hundreds of pages of detail. The task always is to ascertain the meaning of the language used so far as possible.

9. First, beginning with the Decree itself and paragraphs 21 and 22, these provisions precluded the defendants standing pat either in planning for discharges of individuals or in expansion of the system of services generally. For example, under paragraph 21, the determination as to "the type of community placement needed by [each] . . . resident and the scope of services the resident will need when discharged to a community placement . . . shall be made in terms of actual needs of the resident rather than in terms of services presently available" Id. (emphasis added). One use to be made of this assessment is for "planning for and implementing the reduction in institution population required by this Decree and in developing plans for new residential and non-residential community based services." (The second use, as provided for in paragraph 22, is in developing the actual community placement for the individual resident.)

10. Paragraph 14 calls for a net reduction of approximately 800 persons; almost a 30 percent reduction in the census. It was recognized that most of the persons discharged would be more severely handicapped than persons currently being served in the community (Court Monitor's Ex. M, p. 5; Appendix B, p. 18), and pursuant to paragraph 13 within this larger group of more severely handicapped individuals, the defendants could not exclude what in effect amounted to a subgroup of even more severely handicapped individuals "such as physically handicapped persons or persons with severe behavior problems . . . ." The

requirements of paragraphs 21 and 22 as well as 24 and 26, of course, apply to all individuals being placed out of the state hospitals.

11. Additionally, paragraph 16 imposes similar, if not exactly the same, standards with respect to possible admittees to the state institutions. The Commissioner is to see to it that "appropriate" services are to be made available or "developed" in order to divert persons from the institution and serve them in the community.[37] In sum, (1) service delivery was to be based on the actual needs of residents as opposed to what was available; (2) services which were required were for a disproportionately more needy population than had previously been served; (3) a sizeable number of persons were involved; and (4) a similar obligation was imposed with respect to potential admissions which had also been substantial. See note 37. A Decree with these implicit and explicit qualitative and quantitative provisions could hardly be read to codify the status quo, whatever it was.

12. Paragraphs 28-33 called for the hiring of three technical assistance staff, which was to be in addition to personnel within the Department. Paragraph 30. As found in Part II(C), the establishment of these three positions was also called for in the Six Year Plan. The role of the technical assistance staff was to "assist in all phases of the development of community-based services for mentally retarded persons . . . including the provision of technical assistance to persons developing community-based services for mentally retarded persons." Paragraph 28. See also Welsch v. Levine, No. 4-72 Civ. 451,

Memorandum and Order (October 17, 1985). The parallel provision for the staff in the Six Year Plan states: "This objective is designed to establish DPW central office capability to implement the six-year plan in all its objectives as they affect and involve the counties, providers of services, and developers of new services." Appendix B, p. 25.

13. Paragraph 9 of Welsch v. Noot, 4-72 Civil 451 Order Re: Reporting Requirements, January 5, 1980, requires the defendants to report to the Monitor semi-annually, information about new services that are to be developed, training to be provided for licensors, and the following related directly to the technical assistance staff: "A narrative statement outlining the activities of the technical assistance personnel employed pursuant to paragraphs 28 through 33 . . . and identifying significant and potentially pervasive problem areas incurred in the development of community-based programs and services." Id. at 9(b) (emphasis added). Thus, the technical assistance staff functions, as delineated in the Decree, Six Year Plan, and Reporting Order, evince an intent that need for change was contemplated and needed to comply with Welsch.

14. Paragraphs 88 and 89 require the Commissioner to make legislative proposals to implement all provisions of the Decree. Paragraph 89 required the submission of a substantial number of budgetary and other proposals for the 1981 session, all of which relate to improving or expanding community services. The price tag in state funds alone for the said paragraph 89 provisions was in excess of $3 million. Paragraph 89 (a),(d),(e). See also paragraph 89(f) which calls for a proposal to "eliminate the

financial incentives currently encouraging counties to place mentally retarded persons in state hospitals." The significance of this provision was commented on in the six year plan as follow: "This objective addresses a major problem in the provision and funding of residential services. This problem also surfaced in the Welsh v. Noot [sic] case as a major issue the department must face." Six year plan August version, Appendix B, p. 23 (emphasis added).

15. Paragraph 88 provides: "Prior to each session of the Legislature for the duration of this Decree, the Commissioner shall propose to the Governor for submission to the Legislature all measures necessary for implementation of the provisions of this Decree." This provision, as pointed out by the former director of the Mental Retardation Division of the then Department of Public Welfare, "has a much broader and encompassing nature in the phrase, '. . . all measures necessary for the implementation of this decree' [than the provisions under paragraph 89]." Court Monitor's Ex. M, p. 7. See United States v. Atlantic Refining Co., 360 U.S. 19, 23-24.

16. The context in which the Decree was signed, provided further substantiation of the parties' intent.

17. First, the six year plan itself had a number of objectives or action steps which were to be accomplished in order to achieve the ultimate goal of both the plan and the Decree -- to reduce the state hospital population to 1,850 and develop a sufficient number of appropriate services. Appendix B-1, p. 139. Ten substantial objectives were set out (nine in the August version, Appendix B, pp. 14-27), which were frequently

accompanied by proposed statutory changes and budgetary increases, and by their nature, were aimed at changing the status quo. Appendix B-1, pp. 139-154.

18. For example, the fourth objective projected that approximately 800 new ICF/MR beds would have to be made available, as most persons being discharged would require ICF/MR level of care. It noted, however, that 400 beds should become available as a result of higher functioning residents moving from ICF/MR beds to newly developed SILS (objective two), thus requiring a total of 400 new beds.[38] In addition to developing new community homes, the plan further provided that: "Many of the current ICF/MR programs will need modification in order to properly serve the more seriously handicapped state hospital releasees . . . ." Id. at 145.

19. Underscoring the need for change to accommodate and appropriately serve more severely handicapped as well as the effect the 10 percent cap was having on achieving this objective, the MR division director stated:

> DPW's Six-Year Plan is highly dependent upon these facilities discharging their easier-to-serve residents into . . . (SILS) and admitting the more difficult clients from state hospitals. In most instances, this change of population will require a change in program content (e.g., staff, special consultants, etc.) which cannot be made under the 10% limitation. The effect is that most programs are very reluctant to accept the state hospital residents or, when they do, find that they are unable to provide an adequate program for them.

Court Monitor's Ex. M, p. 5. As he further pointed out, another consequence of this problem is increased admissions to the state hospitals when "50% of state hospital admissions are readmissions from ICF/MRs who could not 'handle' the behavior problems with

their existing staff." Id. While this is not precisely a contemporaneous statement, it is of significance. See United States v. Atlantic Refining Co., supra, 360 U.S. 19, 23-24 (1959).

20. The statements from the six year plan and Mr. Wrobel fly in the face of defendants' conclusions. They state:

> The evidence indicates that there was a shortage of community placements in 1980 and that a great many of those in existence were no better than Hearthside. It should have been no surprise that some Welsch class members would be discharged from state hospitals and placed in facilities like Hearthside. Yet the Consent Decree omits any mention of community facilities, other than that they must be 'appropriate' to the individuals' needs. This omission is significant. It is highly unlikely that the Department would have agreed to undertake a reform of scores of facilities which it does not own. The fact that the Decree contains no explicit provision requiring such reform is an indication that it was either not suggested by counsel for plaintiffs or was explicitly rejected.

Defendants' memorandum, pp. 29-30.

21. The six year plan confirms the shortage of appropriate residential programs in September 1980. To infer, based on a narrowly focused view of paragraph 24, placements at programs such as Hearthside would be acceptable and that reform was not contemplated not only is bad logic (based on the Decree), but represents a bit of revisionist history. The six year plan -- and hence the Department -- not only recognized the need for change, but intended to expand and improve the system. In fact, Hearthside seems to typify precisely the kind of facility that the plan was addressing in which improvement may be needed so that it could appropriately serve future class members. See Court Monitor's Ex. M, p. 5; Bock Tr. 1/23/85 (PM), pp. 116-119.

22. Paragraphs 34 and 35 require additional training for licensors, and possibly more of them. These changes are hardly makeweight. As has been previously noted, training of licensors was to focus on habilitative and training areas. While the lack of factual findings again do not depict the precise state of quality assurance when the Decree was signed (which may have prompted paragraphs 34 and 35), the need for change in this area was well documented in a January 1980 document, Minnesota Model Standards, developed under the sponsorship of the Minnesota Department of Public Welfare, Mental Retardation Division and by among others, Dr. Warren Bock. Three major concerns prompted the undertaking of this project, the first one of which was:

> . . . the medical orientation of regulations of services to mentally retarded persons. For the past decade, programs for mentally retarded persons have attempted to focus on normalization, the developmental model, and reintegration of retarded individuals into the mainstream of community living. It is essential that regulations be valid indicators of service quality and allow the expression of contemporary philosophies and techniques in the provision of services.

Court Monitor's Ex. A., pp. 1-2. While paragraphs 34 and 35 certainly speak for themselves, the Minnesota model standards clearly provide additional support for changes and improvements in the licensing area, especially in the areas most emphasized in the Decree and paragraph 34 to wit: habilitation and programming.

Standards Argument

23. Defendants contend again that a single paragraph of the Decree could hardly impose an obligation to issue standards which, as they characterize it,

> . . . apparently require state hospital staff to conduct a searching inquiry into whether a community facility met those standards, including a close examination of the facility's programming data. They argue further that defendants must promulgate standards for individual habilitation plans, to be used to prevent placement unless the facility is independently determined by not only the county, but also state hospital personnel, to meet the standards. See Exh. 31, pp. 111-112.

Id. at 28.

24. For the reasons mentioned in Part V(B)(1), defendants' argument fails. Additional reasons also exist. First, it was the defendants who strongly urged that the Monitor make his ruling on what paragraph 24 required prior to commencement of the evidentiary hearing. Ex. 23, pp. 69-71. While the Monitor declined to do so at that time (see Part I(A)), once a ruling is made, assuming, in particular, it differs from current practice, directives, and/or revisions to existing ones, standards are surely an appropriate mechanism to convey the requirements of the ruling. It has been found that in order to appropriately meet the individual needs of class members community programs must have the capability to develop and implement adequate IHP's. The Decree explicitly requires and emphasizes this point, and the record overwhelmingly demonstrates that the individual habilitation plan is the central feature in a mental retardation service delivery system. It is further found that Hearthside has not had that capability, and as will be discussed infra, Hearthside is certainly not unique in this respect. Given this dichotomy between current practices and the standard required by paragraph 24, the necessity for clear directives and standards is inescapable.

25. Second, the Commissioner has had an obligation independent of these rulings to see to it from the inception of the Decree that state hospitals, counties, providers, and all others who may be serving class members have a clear understanding of what is required by paragraph 24. While, as discussed in the next section, the Department has not totally neglected this area (see, e.g., Exs. 71, 72), the need and obligation has yet to be fully discharged.

26. As plaintiffs point out, relying on Bruce L., the Commissioner, once the Decree was signed, had "the ultimate responsibility for assuring that services are provided" and he "must proceed with vigor and diligence." Plaintiffs' memorandum pp. 10-11. The Commissioner, to carry out his obligation under the Decree, must provide clear guidance to the state hospitals and counties over which he has supervisory authority pursuant to the Decree and the CSSA, Minn. Stat. 256E .01 et. seq., as to what must be met before a discharge may occur and then be maintained thereafter. Personnel delivering services need to know what is required of them.

27. The defendants offer another argument which is essentially two-fold: (1) They lack authority under state law to issue the standards (defendants' memorandum, p. 30), save for promulgation pursuant to Administrative Procedures Act, Minn. Stat. Sec. 1401 et. seq. (Id.); and (2) The issuance of standards would somehow put the Commissioner in a position of reforming community facilities throughout the state as well as the county case management system contrary to his role and function as contemplated by state law and policy. Id. at 39.

28. As plaintiffs point out, the defendants' first argument is undercut by the Commissioner's own actions. The plaintiffs cited and attached five instructional bulletins that have been issued by the Commissioner pursuant to court decisions which, in fact, have altered state policy. Plaintiffs' memorandum, p. 14. The last one cited is dated April 15, 1985. Id. An even more recent example is Instructional Bulletin 85-60 (b), attached hereto as Appendix G, which was prompted by state court approval of an agreement challenging the implementation of newly enacted changes to the state's General Assistance Program. In Welsch, examples exist of such action as well. For example, Commissioner Noot, on April 17, 1981, issued Instructional Bulletin 81-31 addressing two state law issues and also "to inform county or human service boards of their case management, service planning and evaluation responsibilities for persons who are or may be mentally retarded as required in the Welsch v. Noot Consent Decree." Ex. 71, p. 1 (emphasis in text). The bulletin further goes on to state:

> With the signing of that decree, the Commissioner has committed welfare programs in this state to a number of actions, many of which will require cooperation between the state and the counties. . . .
>
> This bulletin is the first of many to come over the next six years, the period of the Consent Decree, detailing county participation in assisting the Department in its implementation of its Six-Year Plan for Mental Retardation Services.

Id. at 2. That bulletin even addressed paragraph 24, although it offered little or no guidance as to how to assure that the placement appropriately met the individual needs of the discharged class members. Id. at 4. Instructional Bulletin 84-55 (8/6/84),

(Ex. 72), which, while citing state law as its authority, was apparently prompted by Welsch and the urging of plaintiffs to develop discharge standards to assure appropriate placements. See Ex. 84, p. 1 "Problem Definition". While, as pointed out infra, this bulletin does not adequately ensure that the requirements of paragraph 24 will be carried out, it nevertheless shows that contrary to the defendants' own statements they clearly have authority to ensure appropriate placements. The bulletin itself was issued "[t]o ensure appropriate community placements for the mentally retarded and to assist the counties in making appropriate placement decisions pursuant to their obligations under Minnesota Statutes, chapter 256E and section 256B.092, and DHS Rule 185 . . . ." Ex. 72, p. 1. The first cite is the Community Social Services Act; the second, the Medicaid Waiver Program; and the last, the state's case management rule. As has already been discussed, the Decree reflects or incorporates portions of state licensing and case management rules such as Rules 34 and 185, and, at least in part, the authority of the Commissioner and his relationship to the counties under CSSA Minn. Statutes 256E. Bruce L., pp. 4-5. Indeed, contrary to the defendants' assertion that the standards contemplated by plaintiffs would run afoul of their authority and role, as plaintiffs point out, new standards would not even be necessary if existing ones under the above-mentioned authorities were, in fact, enforced.

29. To the extent that additional or new directives are necessary to ensure that the current state standards are carried

out or that Welsch is followed, this can be done within and not outside the state-county relationship as it is prescribed by CSSA, Minn. Statute 256E.01-12 which the defendants, in Bruce L., vehemently argued was incorporated in the Decree. Bruce L., pp. 4-5; see also defendants' responsive memorandum in Bruce L., May 24, 1982, pp. 28-42 on file with the Court.

30. Minn. Stat. 256E.08, subd. 1, imposes upon the county the authority and responsibility to provide for:

> (1) an assessment of the needs of each person applying for services which estimates the nature and extent of the problem to be addressed and identifies the means available to meet the person's needs for services; (2) protection for safety, health or well-being by providing services directed at the goal of attaining the highest level of independent functioning appropriate to the individual preferably without removing those persons from their homes; (3) a means of facilitating access of physically handicapped or impaired persons to services appropriate to their needs.

31. It is the Commissioner's responsibility to supervise the county by, among other things, setting standards. Minn. Stat. Sec. 256E.05. Indeed, as the latter section explicitly states:

> Subdivision 1. General supervision. The commissioner of public welfare shall supervise the community social services administered by the counties through standard-setting, technical assistance to the counties, approval of county plans, preparation of the state biennial plan, evaluation of community social services programs and distribution of public money for services.

Id., emphasis added.

32. As can be seen by the statutory provisions, the remedy sought does not require the Commissioner to go beyond his state statutory role and obligation. Potential recommendations are precisely consistent with the Commissioner's role as

envisioned under CSSA in assuring that the counties perform their substantive duty.

C. The Need for Standards

1. Commissioner's Actions Since September 15, 1980

1.1 Welsch class members were placed in a facility which, at the time of their discharge and thereafter, did not (and does not) have the programmatic or staffing capabilities to appropriately meet their individual needs in accordance with paragraph 24. It is also found that neither Hearthside personnel nor other responsible and integral persons involved in the discharge or subsequent IHP process itself (e.g., state hospital discharge team, case managers) have been or are adequately apprised of the requirements of paragraph 24. Of course, while mere apprisal is not enough to assure that the requirements are adequately understood and carried out, it is a necessary precondition. Whether the legal predicate for this finding and the corresponding recommendations are viewed as flowing from paragraph 95(g) or as part of the Commissioner's obligation directly under paragraph 1, the need for clear directives/standards is essential.

1.2 On April 17, 1981, seven months after the Decree was approved by the Court, the then Commissioner Noot issued Instructional Bulletin 81-31 (Ex. 71). The Bulletin in large part merely paraphrased portions of the Decree. With respect to paragraph 24, it stated: "[T]he Consent Decree requires that persons who are discharged from state hospitals must be placed in community programs which appropriately meet their individual

needs." Id. at 5. Beyond that, and merely reflecting the second sentence of paragraph 24, it states that placements must be made in licensed facilities. However, that is a separate requirement of the Decree, and the Department has never claimed, as stated supra, that mere placement in a licensed facility is equivalent to ensuring that a person's individual needs will be met. See Giberson, Ex. 77, p. 8; Court Monitor's Ex. K, p. 6; Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 150.

1.3 Deputy Commissioner Giberson stated in a deposition in May 1984 that no written statement has ever been issued tied to paragraph 24 indicating what standards must be met to comply with the said provisions. Id. at 5-6.

1.4 This has remained the case, although on August 6, 1984, the Department, under Mr. Giberson's signature, issued Instructional Bulletin 84-55, "Uniform Standards for State Hospital Discharge Planning for Mentally Retarded Persons." While this action was prompted because of the urgings of plaintiffs' counsel and the Monitor in the context of Welsch (plaintiffs' proposed findings 3.12), the Bulletin does not refer to Welsch or paragraph 24 as its source of authority but rather relies on state law. Ex. 72, p. 1. That fact may not be problemmatic in itself as the Bulletin's purpose clause is closely analogous to the language of paragraph 24, to wit "to ensure appropriate community placements for the mentally retarded and to assist the counties in making appropriate placement decisions pursuant to their obligations under Minnesota statutes . . . ."

1.5 The Bulletin also represents an improvement over the one issued over three years earlier by setting forth some procedures and factors that should guide the interdisciplinary team in the discharge process. However, it fails to articulate enforceable standards by which to judge whether the potential placement has the capability to properly develop and implement an individual habilitation plan and program. For example, it requires review of some of the salient factors, e.g., staffing ratios, but not against any standard. See Takala Tr. 1/11/85, pp. 75-76 and lines 15-20, p. 76, in particular, Rogich Tr. 1/11/85, p. 138.

1.6 The system is not without rules and regulations. Many of which are relevant to IHP development (e.g., Rules 34, 185). The Minnesota Model Standard Project in urging the adoption of unitary standards, commented on the impact the "plethora of existing state and federal regulations" are having on just residential programs. Court Monitor's Ex. A, p. 1. That was in 1980. There appears to be more rules now. See, e.g., Court Monitor's Ex. G, p. 10. While perhaps it may be time to revive a more unitary approach for the entire system to benefit both class members and non-class members alike, that is beyond the scope of this proceeding.

1.7 What is required, are adequate and direct assurances that the discharge process and the placement of class members conform to the requirements of the Decree and paragraph 24. While Instructional Bulletin 84-55 and Rule 185[40] come the closest, there are still no clear and enforceable standards to guide Department, county, state hospital personnel, and providers

during the discharge process or thereafter in determining whether a placement meets the requirements of paragraph 24. See Giberson, Ex. 77, p. 8; Nord Tr. 3/15/85, pp. 285-286; see also Exs. 81, 82. Despite the numerous rules, and may be in part because of them, no clear directives exist, and as elaborated on later, the result is confusion and conflict or a basic lack of knowledge as to what is required. This has been the case among state hospital and county staff as well as Department personnel, including those who have Welsch responsibilities. It applies to IHP development as well as staffing. As the defendants stated through counsel: [T]he vagueness of the term, 'appropriate' has become a source of tremendous problems for the Department because its [sic] means different things to different people." Ex. 22, p. 70 (emphasis added).

1.8 Plaintiffs' proposed findings 3.24-3.94 pursuasively demonstrate the problem and its effects which is to permit or tolerate discharge procedures and placements, and quality assurance procedures which not only falls below the requirements of Welsch (paragraphs 22 and 24), but the state's own standards as well.

2. Testimony and Statements of Department, County, and State Hospital Personnel With Respect to Criteria for Adequate Individual Habilitation Plans and Programming

IHP's Generally

2.1 In his May 1984 deposition, Deputy Commissioner Giberson (Ex. 77, p. 7), stated the Department's position on what is required by paragraph 24 as follows:

> It is the department's position that a Welsch class member is placed in a community program which appropriately meets their individual needs, if it satisfies the constitutional requirements under the United States Constitution, and if it meets the requirements specifically set out in the Welsch Consent Decree. In addition to that and outside the bounds of the Consent Decree, we would regard the appropriateness of the placement of any mentally retarded person in a community facility to be judged in accordance of the standards of Rule 185 and Rule 34.

2.2 Mr. Giberson also indicated that the Department did not intend to write down and disseminate the Department's official interpretation of the first sentence of paragraph 24 (Id. at 10-11), nor are staff expected to determine or articulate the requirements of paragraph 24, constitutional[41] or otherwise.

2.3 Mr. Nord stated on the final day of the hearing in this proceeding that the issue of whether or not to issue guidelines for use by state and county agency personnel in determining whether or not an IHP has been provided to a Welsch class member which appropriately meets individual needs was being given attention by Dr. Bock, Ms. Kudla, Department counsel, and himself. He stated that the decision whether or not to take such action would be made by Deputy Commissioner Giberson or Commissioner Levine. Nord Tr. 3/15/85, pp. 285-286. Neither Commissioner Levine nor Deputy Commissioner Giberson were called to testify by the defendants.

2.4 Thus, the Department's rather bold position seems to be that whatever is precisely required by paragraph 24, given the legal context in which it arises, there is no intention to publicize it so that personnel can be guided by it. Rather, operationally, state standards such as Rule 185 and Rule 34 will

be used although the Department states it is not necessarily bound by Welsch.[42]

2.5 If Dr. Bock, the Department's Welsch compliance officer, did not know what the constitutional standards were which were purportedly incorporated or required by paragraph 24, one could not expect a county case manager to be better informed. Bock Tr. 1/23/85 (PM), p. 22, 24-25. Dr. Bock answered interrogatories in May 1984 citing constitutional standards as the basis for paragraph 24 requirements (as well as the express terms of the Decree, whatever they are or were) (Ex. 78, p. 3), but when questioned during the hearing about these standards, he said: "I don't have a real good understanding of what Federal constitutional standards are . . . ." Bock Tr. 1/23/85 (PM), p. 22. When asked how a county social worker would determine whether or not a particular placement satisfied federal constitutional standards, his response was, "I don't have an answer to that question." Id. at 24-25.

2.6 The Department employees who testified, three of whom are directly involved in Welsch compliance or related work (Bock, Kudla, and Nord) as well as Mr. Chilberg, all stated that in determining whether or not a setting is appropriate, they are guided by state laws and rules such as Rule 34 as well as the ICF/MR regulations. Plaintiffs' proposed findings 3.18. Dr. Bock spoke in terms of a "nearly deficiency free" Rule 34 licensing standard. Bock Tr. 1/23/85 (PM), pp. 57-58. Both Nord and Bock referred to additional factors such as peer relations, family contact, etc. Mr. Nord also believed it would be appropriate to place someone if a client would be better off than at

not B.

the state hospital, a theme echoed by county personnel, although one Mr. Nord believed was the Department's official standard. Nord Tr. 3/15/85, p. 255. Ms. Kudla had developed her own standards which tracked the above-mentioned rules as well as an additional one, Rule 10. As she stated:

> This is not the department's standard. This is the standard that I use utilizing the existing departmental standards. The department standards are the existing regulations; Rule 34, Rule 10, et cetera. In utilizing Rule 34, Rule 10, as well as the ICF/MR regulations, I make this interpretation, or this judgment, on reviewing those particular program plans. Some of the language that is used here, is similar to what is written in the departmental rules, yes.

Kudla Tr. 12/21/84 (AM), p. 81.

2.7 On the county level, while several of the case managers and their supervisor, Ms. Takala, were able to state in general terms that the programming and staffing capacity of the facility were factors considered in determining the appropriateness of a placement (e.g., Takala Tr. 1/11/85, pp. 72-73, 75-76; Takala Tr. 3/6/85, pp. 120-121), they reflected a lack of knowledge of what in practice constitutes an appropriate IHP as well as an appreciation for the importance of standards of quality officially promulgated or not. See Takala Tr. 3/6/85, pp. 120-121. An example Ms. Takala gave of a more sophisticated program plan at Hearthside in 1985 than in 1980 was as follows:

> A Well, one, there's a goal. Specifically who's going to implement this goal, how often it's going to be --
>
> Q Is that the kind of more sophisticated program you're talking about?
>
> A Right.

Q Have you other examples of more sophistication in Hearthside programs?

A No.

Id. at 122. Delores Rogich who exercised case management responsibilities of class members Mark and Delores (Rogich Tr. 1/11/85, pp. 93-94), made no reference to the facility's capability to develop and implement an IHP which appropriately meets an individual's needs. She stated that she had been given no explicit instructions to follow in order to determine whether an individual placement would in fact appropriately meet a person's needs. Id. at 138. She also did not mention staffing as a criteria, as discussed below.

2.8 Craig Anderson is a social worker who has been employed by MLSH for the past eleven years. Anderson Tr. 1/11/85, p. 218. He was involved in discharge planning for class members Dan and Delores. Ebacher is presently a social worker for St. Louis County; however, he had been a social worker at MLSH for about four years until he left that position in March 1985. Ebacher Tr. 3/6/85, pp. 18-19. He was Mark's social worker at Moose Lake when Mark was placed at Hearthside Homes. Id. at 21. As social workers of the discharge team at the state hospital, they would be the key persons involved in the discharge and the placement from the state hospital's end. Three observations can be made about their testimony concerning the process, factors, and standards they utilized in the discharge process of the three class members. First, in none of the discharges of the three class members did they (or apparently the team) make a direct determination about the programmatic capability of the

potential provider for each class member (plaintiffs' proposed findings 3.60, 3.67) but rather relied either on the county's assessment, the provider's assurances or the fact that the facility was licensed. Plaintiffs' proposed findings 3.60, 3.64, and 3.66. For example, Mr. Anderson who is involved in class members' placement in September 1984, stated the following with regard to how provider programmatic capability is examined.

> A Personally, I don't follow -- I don't follow any because that has not been my responsibility.
>
> Q Who responsibility is it on the discharge team?
>
> A The county's.

Anderson Tr. 3/6/85, p. 106.

2.9 Second, the team, or at least the social workers, do not follow any standards by which to judge whether or not a home can adequately develop or implement an IHP (plaintiffs' proposed findings 3.67), rather they collectively make a judgment whether or not a client will be "better off" than his/her current status at MLSH. Plaintiffs' proposed findings 3.58, 3.63. In making that judgment they look at such factors as the characteristics and compatibility of peers of the prospective provider, family ties, environment, activities, and potential for improvement. Id. at 3.53-3.58, 3.63.

2.10 Third, Mr. Ebacher testified that the way placements were some times begun was at the initiation of providers who would call when there was an opening in their facility. Ebacher Tr. 3/6/85, p. 36. For Mark, he received a telephone call from Hearthside to the effect that: "Hey, we got an opening, you know, in our ICF/MR." Id. at 36-37. This is not an

uncommon way in which the discharge process is initiated and apparently occurred with respect to Delores. Anderson Tr. 1/11/85 (AM), pp. 229-230.

Staffing

2.11 Relying largely on the testimony of Messrs. Anderson, Ebacher, and Ms. Takala, defendants state that the discharge process has improved since 1980 and particularly for Delores (defendants' proposed findings 34-37), who was discharged shortly after the issuance of Instructional Bulletin 84-55 (see Id. at 184-185). The defendants claimed that one area of improvement was that personnel looked more closely at staffing ratios.

2.12 As mentioned above, county workers reflected an inadequate appreciation of the importance of programming or the standards by which to judge programming. As to staffing, Ms. Takala did testify that this was now taken into account, and when cross-examined, said that staffing was specifically figured into Delores' placement. Takala Tr. 3/6/85, p. 120. However, she then stated that:

-- she did not know the staffing standard being applied to judge the adequacy of the staffing, but believed the case manager, Ms. Rogich, knew (Id. at 121); and
-- that Ms. Rogich would also have been aware of the actual staffing ratios at Hearthside and that she (Ms. Takala) had in fact informed her of staffing increases there. Id. at 120.

2.13 When Ms. Rogich testified, a different light was cast. First of all, when asked what she considered in determining the adequacy of placements, she did not ever mention staffing as a criteria (Rogich Tr. 1/11/85, pp. 135-138), nor had she ever been given any explicit instructions as to what standard to follow for staffing, or anything else. Id. at 138. When specifically questioned about staffing at Hearthside in relation to Delores, she clearly did not have a firm grasp of what was necessary to meet Delores' needs and how many staff were on duty. See, e.g., Id. at 117. She also stated she did not check with either the Departments of Health or Public Welfare to see if Hearthside had been cited for any deficiencies (Rogich Tr. 1/11/85, p. 146), but relied on her supervisor, Ms. Takala, who indicated that there were no restrictions.[43] Id.

2.14 State hospital personnel, as part of the discharge team, do have and have had an official role in judging the adequacy of the placement both under Instructional Bulletin 84-55 and previously. Both Mr. Ebacher and Mr. Anderson testified that staffing ratios are now considered in the placement process. Ebacher Tr. 3/6/85, p. 30; Anderson Tr. 3/6/85, pp. 92-93. Turning again to the most recent placement on the record, namely Delores', Mr. Anderson testified in judging whether Hearthside's staffing was adequate to meet her needs that reliance had been placed on Ms. Rogich who had indicated that staffing was "adequate" in a "Community Needs Assessment" document. Id. at 94-95.

2.15 Thus, if as defendants state, there has been improvement in the discharge process since 1980 or since the

Discharge Bulletin as exemplified by Delores' placement and in considering staffing in particular, the improvement is not significant or adequate. Indeed, as Delores' placement indicates, the lack of standards and knowledge still infect the process.

2.16 The record also shows that in 1982 and 1983, MLSH discharge teams also placed six individuals into Hawthorne House. Ebacher Tr. 3/6/85, pp. 57-58, 103), a facility that although licensed, had staffing ratios which were so low that safety issues were raised by the Department itself. Bock Tr. 1/23/85 (PM), p. 80-81; Ex. 85. Thus, while it is the Department's position that Instructional Bulletin 84-55 is adequate as it defers to the professional judgment of state hospital and county personnel as to the adequacy of staffing, it would appear that in reality more clarification and accountability is needed with regard to the process as well as the actual standard to be used. The evidence indicates that this has certainly been the case prior to 1984 (as exemplified by the Hawthorne House placements) as well as even after the issuance of Instructional Bulletin 84-55.

2.17 The evidence showed that while the County was aware and acknowledged staffing deficiencies, apparently because it was a licensing matter and Hearthside was licensed (although being investigated and cited for staffing deficiencies), it deemed staffing "adequate" for placement of Delores. State hospital staff apparently does not look to licensing but rather deferred to the County's judgment that staffing was adequate.

* * * * * *

2.18 Three concluding points are in order. First, the evidence shows that the discharge process may well be initiated by the provider who notifies the state hospital that it has an opening. (Finding 2.10, above.) However initiated, the state hospital staff both as to the programmatic and staffing capability of the facility defer to the county. (Findings 2.8 and 2.14, above.) The county is not adequately guided by nor does it apply any standards for staffing or program capability sufficient to ensure that class members' needs will be appropriately met. As a consequence at Hearthside, County staff did not apprise themselves as to precisely what the staffing situation was let alone make a determination as to whether the quantity or quality of the staff could adequately meet the class members' needs, including in Delores' case, the most recent placement. In fact, what they did know, shows that deficiencies in staffing and programming did exist at Hearthside, yet apparently believed they were off the hook because Licensing had not placed any restrictions. In short, the state hospital relies on the county; the county relies on Licensing, or more precisely, Licensing's silence.

2.19 Second, the fact that a facility is licensed and even deficiency-free should not absolve the county from making an independent determination that a placement has the programmatic and staffing capability to meet the individualized needs of the class member under consideration for placement. This is the case not only as a matter of law, but as a matter of practice, because Licensing uses (a) minimal standards and (b) applies them more to

the facility as a whole, rather than through a more individual-by-individual approach. This is why a facility can be licensed, but not necessarily meet the individual needs of a particular resident/client.[44] Ex. 77, p. 8.

*2.20 Finally, Department personnel do not know what is required to assure an appropriate placement under Welsch, and have each developed different criteria (finding 2.6, above) which may not reflect the Department's position (see, e.g., Id.). The Department itself, its personnel, the counties and the state hospitals all need guidance. It is the obligation to supply not only of Welsch, but because the structure and nature of the state-county system under CSSA, compels it. It is a system which, as stated above, is predicated in large part on the exercise of standard-setting role by the Department.

D. Case Management

1. The findings below are addressed to how effectively case management performed its role in providing and ensuring adequate services to class members during and upon the completion of the 60-day evaluation period under paragraph 22(e), and then when the class members were permanently discharged. The findings in the previous section concerning the case managers' role during the discharge process itself, are also relevant in the consideration of this overall issue. In Minnesota, as in many states, in addition to licensing, the central mechanism (external to the provider) designed to assure provision of adequate services is case management. In tandem with the ISP/IHP process, case management has been recognized as an essential ingredient in the

deinstitutionalization process and in ensuring quality, coordinated services in the community. Bruininks, et al., pp. 79-80, 89-90; see Part II(C)(2.9), supra.

2. As stated in Rule 185 (see defendants' proposed findings 151), the "case manager [is] the individual designated by the county board under part 9525.0035 [emergency] to provide case management services" (Mn. Rule 9525.0015 [emergency] subp. 5, Ex. 70, p. 1 (emphasis added). The job includes "identifying the need for, seeking out, acquiring, authorizing, coordinating, and monitoring the delivery of services to, and protecting the rights of, persons with mental retardation . . . ." Id at subp. 4. See Ex. 70, pp. 8-10. As is evident from the list of functions, the case manager is the common denominator for all services -- residential, day program, ancillary, etc. Not only is he/she involved in identifying and delivering services, but he/she is ultimately responsible to ensure their coordination and quality.

3. The Rule in its current as well as previous forms, represents a codification of a clear consensus of opinion concerning the role of the case manager in the service delivery system. As put by the Department's technical assistance staff:

> If there is a single most critical service in the mental retardation service system, it is case management. This is the service that mobilizes all other services, and applies them to the benefit of the client. It is the responsibility of the county, the local social service agency, to provide case management, and all of the rest of the service system has been predicated upon case management being provided and provided effectively.

Court Monitor's Ex. K, p. 2 (emphasis added). They go on to describe the skills needed to effectively perform the job:

> For case management to be an effective intervenor in the lives of those people who are the subject of our concern (people who have many, whole-life problems that are resistant to can-opener solutions), its role must be vastly more aggressive and ingenious than that of an eligibility technician. A case manager is responsible for generating and applying solutions that are not necessarily self-evident and that call for a very substantial amount of professional judgement, as well as for substantial energy and commitment to the person being served. It is a demanding role. It is the role of a creative and active problem solver. In addition, it requires the skill of understanding and integrating technical information.

Id.

4. The Department's official view of the role of case management and Rule 185 is consistent with the importance placed on it in the above passages. As noted by the Legislative Commission to Review Administrative Rules report, November 27, 1984 "[t]he Department considers the case management requirement of the Rule [emergency Rule 185] crucial to meeting legislatively and judicially imposed mandates to provide for the care of the mentally retarded in the least restrictive environment." Dept. Ex. 5, p. 1. See also defendants' proposed findings 147, 148, 151 and plaintiffs' proposed findings 7.39 and 7.42. In short, the Department does not take issue with the importance of case management in the provision of services.

5. In addition to (or as an alternate to) their relevancy argument about the consideration of case management, they state that it is improving across the state, primarily through the promulgation of the current emergency Rule 185 in October 1984. What effect these revisions to Rule 185 will have in the future, as discussed above, is speculative particularly given the history

of lack of full enforcement and the variance provisions under the current version of the rule (see note 40) as well as the nature and scope of the problems that need to be addressed.

6. Prior to the fall of 1984 there appeared to be little dispute that case management was not being performed adequately and with respect to specific class members to ensure that their needs were being appropriately met. In January 1984, the Department's own consultant raised concerns about the case management services provided to class members Dan and Mark based on his reviews of the plaintiffs' report and county's response, concerns that he later confirmed when he visited Hearthside. Amado, Tr. 1/25/85 (PM), pp. 118-119. The consultant, Dr. Amado, in his January 1984 memorandum to Dr. Bock stated:

> The county has been negligent with regard to case management. The county case workers have certainly not advocated for appropriate habilitative services. It is probably safe to assume the county workers have no understanding of the current state-of-the-art in services for people with developmental special needs, and, therefore, do not fully appreciate the needs of their clients nor the services from which they might benefit.

Ex. 117, pp. 6-7.

7. Relying almost exclusively on the testimony of Barbara Takala, the St. Louis County case manager supervisor, the Department outlined a number of changes that Ms. Takala indicated had taken place particularly since the fall of 1984. Defendants' proposed findings 155-157, 159, 161-169. However, actual performance and implementation is more probative as to whether or not there has been actual improvement.

8. St. Louis County uses two-person case management teams who are responsible for a discrete caseload to perform case

management functions. Judy Forte has been the prime case manager for Dan since September 1982 and for Mark since shortly after his placement. Forte Tr. 1/11/85, pp. 149-155, 212-213. She is currently on a team with Ms. Erchul and their caseload is approximately 92 persons, approximately 60 of which are persons with mental retardation including residents of Hearthside. Forte Tr. 1/11/85, pp. 157-158. They are the team primarily responsible for the residents at Hearthside. Id. at 28. However, Ms. Rogich, who is a member of another team, actually exercised most of the case management responsibilities for Mark and Delores while they were at the state hospital and up until approximately sixty days after their placements at Hearthside. Ms. Rogich is on a team with Ms. Isaacson and their caseload consists of approximately 100 persons, about two-thirds of whom are persons with mental retardation. Rogich Tr. 1/11/85, pp. 93-95.

9. The thrust of Ms. Takala's testimony, as summarized in defendants' proposed findings 155-157, 161-169, is that she adequately carried out her supervisory and professional responsibilities, that case managers in St. Louis County, to include Ms. Rogich and Ms. Forte, are trained in and adequately carry out their responsibilities including such things as the development and evaluation of IHP's and programs in conjunction with and as chairpersons of the interdisciplinary team, and that improvements in these areas have occurred since 1980 and recently as well. While the record does reflect changes, the preponderance of the evidence indicates that performance of St. Louis County case management, even recently, has not been effective in ensuring that class members' needs are adequately met.

10. As indicated in section C, supra, the county case managers have not adequately performed their role during the discharges of Mark and Dan and even Delores which occurred in September 1984.

11. Neither Ms. Forte nor Ms. Rogich have had formal course work or training in their post-secondary education experiences or as part of inservice specifically directed to the development of IHP's. See plaintiffs' proposed findings 7.55-7.58.

12. Rule 185 requires that case managers chair the inter-disciplinary team meeting responsible for the development of the IHP. The case manager is ultimately responsible for assuring that it is adequate. On September 28, 1984, Ms. Rogich was present at a team meeting on class member Delores. She had little or no knowledge of the results of the assessments done separately by the DAC and Hearthside upon which, at least in part, the IHP was to be developed. Rogich Tr. 1/11/85, pp. 125-126.

13. In spite of the fact that relatively recent assessments had been done on Delores (to wit the "Michigan Assessment" and the "Adaptive Behavior Scale") in September 1984, when the county developed Delores' December 1984 Individual Service Plan, they used a June 1984 MDPS assessment done at MLSH. Plaintiffs' proposed findings 7.61.

14. Ms. Isaacson, the other member of Delores' case management team, was the person who drafted the December 1984 individual service plan and she did so with minimal contact with

Delores or knowledge about the case. Plaintiffs' proposed findings 7.61, 7.63. Ms. Rogich, who was acting at that point, not as Delores' case manager but rather as her guardian, signed Delores' ISP in her said guardianship capacity and did so without making any judgments about the plan deferring instead to its prime author or colleague Ms. Isaacson, who as indicated, had little knowledge about Delores. Rogich Tr. 1/11/85, pp. 122-126.

15. The case manager apparently still does not chair interdisciplinary meetings. Rogich Tr. 1/11/85, p. 108.

16. At odds with Ms. Takala's statement that a facility would contact a social worker before making any major changes to an IHP (Takala Tr. 3/6/85, pp. 145-146), changes in two of Mark's major program areas, communication and behavior management, were made without the knowledge of his case manager, Ms. Forte. Plaintiffs' proposed findings 7.66-7.70.

17. The duty to assure that services are provided in a quality manner is at the core of the case manager's duties yet, at times, both out of a lack of knowledge of the subject matter or perhaps because of a lack of a true understanding of the role of case manager, St. Louis County case management staff failed to follow up or assure that needed changes to individual programs were made, or that other initiatives were undertaken. For example, Ms. Takala did not follow up on the recommendations made by Mr. Chilberg regarding integrated communication programs for Mark and Dan after the February 1984 review at which she was present. Takala Tr. 1/11/85, pp. 65-66; Ex. 54, p. 20. See also plaintiffs' proposed findings 5.75.

18. Ms. Forte, in the response she prepared to plaintiffs' counsel's original report, agreed with the observation that no teaching methods were included and that recording of program progress was poor. Forte Tr. 1/11/85, pp. 173-174; Ex. 8, p. 30. She also indicated that that situation existed prior to plaintiffs' report in October 1983. Forte Tr. 1/11/85, p. 174. Apparently neither she nor her supervisor, Ms. Takala whom she talked with about this concern, did anything about it at the time and nothing happened for a few months. Id. at 174.

19. Ms. Takala failed to follow up either directly or through her staff on whether or not Hearthside began implementing Dr. Amado's recommendation to utilize discrepancy analysis as part of their teaching strategies. She did not follow up on this in large part because she did not understand what discrepancy analysis was nor did she attempt to gain further information. Takala Tr. 1/11/85, pp. 56-57. Hardly consistent with the role of an effective case manager, let alone a supervisor, she made the following additional comment about Dr. Amado's recommendation: "He gave them many suggestions and they were suggestions and not orders as I understand it. These were ways they could make things better." Id. at 59.

20. On several levels, the evidence indicated failures to properly observe, monitor, and evaluate program implementation and its impact on class members. For example, case managers do not observe programming during the afternoon at Hearthside after class members come back from the DAC. Plaintiffs' proposed findings 7.72-7.73. Quarterly reviews of each client's program lasts for approximately five minutes per resident. Thoreson Tr.

3/15/85, pp. 157-158. There is a gross over reliance on staff at the facility on whether or not programs are effective. Previous to January 1985, Ms. Forte did not review actual data sheets but accepted staff interpretation of the data. Forte Tr. 1/11/85, pp. 188-189. In her testimony on January 1985, she indicated that data sheets were now being examined at the reviews. Id. at 214. Yet, when Mr. Thoreson testified in March 1985, he indicated that the case managers had not asked for any data sheets for Welsch class members. Thoreson Tr. 3/15/85, p. 159. Ms. Rogich checked "yes" blanks on the after-care plan or discharge plan for Delores as part of her 60-day evaluation indicating that Delores' various needs were being met. Ex. 101, pp. 2-4; Rogich Tr. 1/11/85, pp. 105-106. See also Ex. 101, pp. 6-8. Ms. Rogich did this despite the fact that she did not review Delores' behavior program at Hearthside or the data from that program; she merely relied on staff comments. Rogich Tr. 1/11/85, pp. 113-115. Delores' behavior, as discussed supra, was of much concern at that time.

21. Deficiencies or no progress existed in virtually all of Delores' programs at the time of the 60-day evaluation yet Ms. Rogich did not review the programs or program data and again, relying on staff, concluded that her needs were being met. In addition to the behavior program, these included Delores' bathing program, care of clothing program, fire drill and evacuation program, meal-time program, a one-to-one program, a communication program, and a hair-combing program. Plaintiffs' proposed findings 7.80-7.86. A lack of training on the role of a case

manager was also evidenced in Ms. Forte's lack of knowledge about whether it was her responsibility to point out to staff that on class member Mark's table manner program, they were asking for a level of performance in spilling, but not collecting any data on it. Forte Tr. 1/11/85, p. 190. She also did not know whether it was part of case management responsibility to coordinate behavior modification programs between a residential facility and a day facility. Id. at 194.

22. In the semi-annual reports to the Court Monitor required by paragraph 9 of the Welsch v. Noot, supra, Reporting Order (January 5, 1981), the technical assistance staff characterize the problems of case management as a "crisis" in Minnesota, stating specifically in their June 30, 1984 report (Ex. K, p. 2):

> There is even substantial resistance to the idea that case managers should be required to have training and experience in mental retardation.
>
> In point of fact, there are very few current case managers who are trained for the job. There is no commonly available program of training for case managers, nor even a statewide program of orientation to the role.
>
> The state Regional Services Specialists can help by providing technical assistance, but they cannot substitute for the direct and critical case management that is expected to ensure delivery of appropriate and effective benefit to the client.

23. The staff's most recent report to the Monitor for the period of January 1, 1985 to June 30, 1985, while dropping the word crisis, reiterates the precise same problem.[45]

24. The Mental Retardation Program Directors of the state hospitals made the following observations about case management in early 1984.

5) . . . Contrary to Rule 185, no CWD currently develops an aftercare or discharge plan in the sense of assuming responsibility and authority for the carrying out of this task.

6) At the present time, there are no field staff of the DPW whose primary role and responsibility is to communicate with CWD staff and specifically address the social workers need for training, consultation and support in their carrying out of the case manager role. 47

7) Case management caseloads of CWD social workers in many agencies are large, frequently assigned to the least experienced, trained and skilled worker. As a result, case management functions are in effect carried out by residential providers including the state hospital.

8) The primary stimulus, in most cases, for community placement of the class residents eminates from the state hospital staff.

9) Residential providers, in most cases, pressure the CWD and the state hospital staff for quick decisions and at times abrupt planning of discharges due to financial concerns eminating from vacant beds.

. . .

11) County case managers do not feel they have the authority to effect and bring about change in community provider programs to meet the needs of state hospital residents nor are many confident of their competence to know how to fix a program that is not working for a client.

12) County case managers are not confident of their role or skills in developing services as alternatives to the current available service array in the county. They are able, in most cases, to utilize only what exists and is available.

13) County case managers are not confident of their ability to utilize program data and documentation and lack skills in monitoring programs effectively through its use.

Ex. 84, pp. 1-2.

25. The observations concerning case management throughout the state are generally applicable to St. Louis County

(plaintiffs' proposed findings 7.111 (a)-(e)), and based on the most recent technical assistance report, continue to persist statewide. See also note 40.

E. DHS' Licensing Efforts

1. Rule 34, Mn. Rules §§ 9525.0210 to 9525.0430 (Ex. 86), which was developed well prior to the Welsch Consent Decree is the primary rule in which the Department directly licenses, and assures that residential programs, to wit ICF/MR's such as Hearthside, meet minimal standards of operational quality and provide for the needs of its residents. Plaintiffs' proposed findings 7.16.

2. As the Department and the technical assistance staff itself, use and apply Rule 34 standards (among other standards) in their Welsch compliance efforts and because of the interrelationship or reliance, direct and indirect, of the Decree to Rule 34 and Licensing (paragraphs 24, 34, 35, 63, see also 22(c)) it is relevant to examine how the Commissioner has performed his ultimate duty of assuring that class members placed in the community receive services in accordance with paragraph 24. See also defendants' proposed findings 198. This is particularly so since it does not make legal or practical sense for the Commissioner, himself, to "travel around the state trying to 'fix'" each of the more than 330 community residential facilities that apparently exist in Minnesota. Defendants' memorandum, p. 39.

3. There has been progress in the licensing aspects of this matter. Evidence of improvement is demonstrated by the Chilberg/Amado visit in February 1984 and the April 12 follow-up

letter to Abrahamson (Ex. 54), the Department's February 22, 1985 licensing letter to Abrahamson signed by Assistant Commissioner Margaret Sandberg (Ex. 59), and licensing examiner Chilberg's somewhat unofficial but candid response to Ms. Kudla's staffing analysis in the spring of 1985. Compare Court Monitor's Ex. T with Dept. Ex. 14.

4. However, as is evidenced by the continued deficiencies in programming and staffing at Hearthside, it cannot be reasonably concluded that the Department's licensing arm, either independently or in conjunction with case management, is effectively ensuring that the needs of class members are being appropriately met.

5. In fact, its efforts (or lack thereof) have in some respects been counterproductive to ensuring that the needs of class members have been appropriately met. It cannot be overlooked that from 1974 to 1984 Hearthside has been fully licensed. As indicated above, it was not until April 1984 and February 1985 that Hearthside was cited for major deficiencies in the programming and staffing area and that its license had come under close scrutiny.

6. It is reasonable to conclude, based on the record, that the deficiencies uncovered by the plaintiffs and acknowledged by the defendants in testimony and in their licensing letters, existed during the period in which Hearthside had been fully licensed. This includes the last time in which Hearthside's license was fully renewed in August 1983, just prior to plaintiffs' visit and report in August 1983 and 1984. As

noted above, the Licensing Division and the very licensing examiner who year after year renewed Hearthside's license after plaintiffs' visit and report, acknowledged virtually every deficiency described by plaintiffs. Exs. 53 and 54. It was also not until August 1984, after the Notice of Non-compliance, that Hearthside's license was extended on a month to month basis. Abrahamson Tr. 3/15/85, p. 38; Chilberg Tr. 1/25/85 (AM), pp. 25-26, 29. It is thus reasonable to draw the inference that but for plaintiffs' investigation and the subsequent Court Monitor's Notice that Hearthside would have been continually licensed and the facility and the class members' programs would not have been subject to the level of scrutiny Licensing has only given it. Thus while weight must be given to the positive steps that have been taken in Licensing, their performance in this area prior to plaintiffs' inquiry cannot be disregarded.

7. Even after plaintiffs' inquiry and/or the commencement of this proceeding, the Department and its Licensing arm has not shown itself effective in addressing problems within its domain.

a. While plaintiffs pointed out staffing deficiencies in the October 1983 reports (which existed and went unnoticed or uncited previously), it was not until February 22, 1985 that Hearthside was cited on that count (plaintiffs' proposed findings 7.24), and even with that, as discussed below, no solution has apparently been worked out or ordered.

b. With regard to program issues, there has been a failure on the part of licensing examiner responsible, Robert Chilberg, to exact true corrections or deficiencies which he

noted at Hearthside, and then to follow through on a few commitments he received from the facility.[48] Id. at 7.23.

c. There has been an overreliance on staff instead of independent scrutiny as evidenced by the fact that Mr. Chilberg relied on Hearthside's program coordinator Jungwirth's statements that Mark's behavior had improved, when "a modest investigation" would have revealed otherwise. Id. at 7.25.

d. Of more than academic concern was licensing examiner Chilberg's testimony that he takes into account problems faced by lower per diem facilities when he evaluates them for licensing purposes (Id. at 7.27) as well as his testimony that program methods (implementation strategies) need not be part of an IHP (Id. at 7.36). A similar comment was made by the Welsch Compliance Officer and former Deputy Director of the Mental Retardation Division of the Department, Dr. Bock. Id. at 7.37.

e. Even the Licensing Division's most recent letter issued by the Department on February 22, 1985 (Ex. 59), misses the mark in several important respects. While much of the corrective action required is prospective (Ex. 59, pp. 2-9), the evidence in the record already indicates that some of the remedies are not adequate on their face or as implemented as is more fully discussed and found in Part VI (22-25).

8. Another area of concern is the fact that Licensing does not inform state hospital officials of formal licensing action taken against a facility (plaintiffs' proposed finding 7.32) even when the findings are potentially relevant to the facility's capability of being able to appropriately meet the individual needs of class members who may be discharged there.

8.1 When a licensing investigation is in process, and formal action has not been taken, the Department is prohibited by the State's Data Practices Act, from disclosing the information to either county or state hospital officials even if gross deficiencies are being uncovered. Plaintiffs' proposed findings 7.33. Dr. Bock was unaware of efforts by the Department to obtain needed and appropriate legislative modification to the Law so that relevant information could be released during a licensing investigation. Bock Tr. 1/23/85 (PM), pp. 85-86. Whether the Department can or is doing something administratively was not broached.

9. Defendants stated that 11 additional licensing examiner positions were being requested from the Legislature "to meet the expanding licensing categories, to reduce caseloads and increase the frequency and quality of licensing reviews." Dept. Ex. 3, p. 2; defendants' proposed findings 189. A special investigative unit was also supposed to be set up. Mr. Chilberg testified that his territory included all of northeast Minnesota beginning with Anoka County. Chilberg Tr. 1/25/85 (AM), p. 91. He has jurisdiction over about 40 Rule 34 facilities and many other programs for persons with mental illness, chemical dependency, physical handicaps, who are in foster care, etc. Id. 24-25. The record does not reveal whether the Department received all the positions it requested. Informational Bulletin 85-105, December 5, 1985, indicates that Licensing was reorganized, but it is unclear from that document whether and how many new licensing positions were obtained to meet the obvious need. See also paragraph 35 of the Welsch Consent Decree.

F. The Contributing Factors Are Neither New Nor Unique

1. Defendants point out that Rule 185 is "the heart of the case management system." Defendants' proposed findings 151. It is acknowledged by all that case management is perhaps the key mechanism in the state to ensure that the needs of class members (and non-class members alike) are met. Yet, by the Department's own admission up to October 1984, Rule 185 was never fully enforced. See note 40. The issue of the adequacy of IHP development and staffing in community programs had been raised as early as 1982 under the Consent Decree by plaintiffs. Plaintiffs' proposed findings 8.2, 8.3. See also Ex. 26, p.92 and Ex. 81. These are problems which have been recognized by the Department since at least 1982 (see Court Monitor's Exs. M, p. 5; A, pp. 1-2; K, pp. 1-7) and anticipated before that time at least as early as 1980 as the Decree was being negotiated. Appendix B, pp. 18, 23-24.

2. Ms. Takala testified that she believed that Hearthside's programming capability was about average for St. Louis County. Takala Tr. 3/6/85, pp. 112-114. The thrust of Mr. Nord's testimony was that based on the 150 programs he had reviewed, he concluded that there were many facilities throughout the state in which class members were placed which had similar needs and deficiencies as Hearthside. Nord Tr. 1/23/85 (AM), pp. 96-98; Nord Tr. 3/15/85, pp. 210-211, 286-291.

3. Defendants state that they do not have the resources to individually monitor 7500 client individual program plans which change on a quarterly basis. Defendants' proposed findings 171. They further state that it is the county's case manager's

responsibility to determine programmatic capability of a community facility. Id. at 172. While the number 7500 represents the total number of individuals in the system and considerably fewer class members are involved, whatever the number is, this is precisely why clear directives or standards must be issued and enforced to carry out the mandate of Welsch so that the counties and state hospitals and private providers and their respective personnel may at least know what they are supposed to do to appropriately meet the needs of class members.

4. This is consistent with the CSSA, which as mentioned above, provides that the Commissioner shall perform, among other things, a standard setting role.[49] Mn. Stat. 256E.05. The Department has not been unmindful of its role and has understood it generally (August 1980 Six Year Plan, Appendix B, pp. 70, 77), and in regard to the need for standards to ensure appropriate program quality. In April 1981, pursuant to Mn. Stat. 256E.04, the Department in its first CSSA "Biennial State Plan" to the Legislature, proposed as one of its major goals, the development or revision of "program and service standards, as necessary, in order to protect mentally retarded persons from violations of their human and civil rights to assure that the appropriate program and services are provided to mentally retarded persons based on their needs." See Appendix B-1 (January Six Year Plan) and the "Proposed State Biennial Community Social Services Plan" attached, p. 169 (April 1981).

5. Over two years later, after Commissioner Levine took office, he indicated that as applicable the Quality Assurance

Plan for State Facilities would at "every opportunity" be implemented in the community services system through "DPW rules and guidelines." Court Monitor's Ex. G, second page. As mentioned above, this Plan has as its purpose the assurance of quality treatment and habilitation programs to residents of the state hospitals, including class members while they are institutionalized. Id. at 1.

6. As this proceeding demonstrates, despite the above statements, the goal of developing program quality standards continues to elude the Department. The lack of such standards has been noted by the technical assistance staff as one of the potentially pervasive problems areas incurred in the development of community programs in their Semi-Annual Report to the Court Monitor (Ex. K).

> A persistent problem in the provision of good quality services, in the residential, day, and support areas, is the absence of explicit quality standards.
>
> > Licensing standards are in place, and they are essential to have. However, licensing standards are mostly directed toward health and safety, and are expressed substantially in terms of the physical plant. This is necessary, but not sufficient; they do not give equal coverage of the means and results of the service, that is, to the program itself. Further, licensing standards are necessarily set at the minimum acceptable level, and do not in themselves promote higher quality programming. The Licensing Division suffers from inadequate staffing and from variability in rule interpretation and citation of deficiencies. Changes in leadership and clarification of rule interpretation will facilitate improvement in this.

Id. at 6 (emphasis added).

7. The need for "explicit quality standards" has clearly been demonstrated in this case. While it is important to vest discretion with professionals (Bock Tr. 1/23/85 (PM), pp. 45-49), the direct and indirect activities they and others perform must be carried out in accordance with standards which result in placement of class members in a setting which meet their individual needs. A clear understanding of what is expected is essential not only in apprising personnel on how to properly develop and implement an IHP, but to ensure that other components of the system work toward the same end, e.g., licensing, technical assistance, case management. Indeed this proceeding shows that not only do the frontline providers need guidance, but case managers, the licensors, and even Department personnel do so as well in carrying out their respective functions.

8. While there are many examples in Minnesota of fine community programs serving persons with mental retardation, including class members, and those examples will exist with or without standards, to ensure that paragraph 24 is carried out consistently across all programs which serve class members, standards are needed. See Matson and Mulick, pp. 2-4; Scheerenberger, pp 5-6.

9. There are also counterveiling pressures on the system and providers which add to the case. The vicissitudes of human nature being what they are, coupled with financial restraints, underscore the need for clear and enforced standards. Matson and Mulick, pp. 19-20. This is particularly so given the vulnerable position of class members who as individuals are at an extreme disadvantage relative to most consumers. As the Department

insightfully pointed out in its Quality Assurance Plan for State Facilities (Court Monitor's Ex. G, pp. 33-34):

> But it is more difficult to maintain and assure quality services for persons in state operated facilities than in many other types of health care settings. A large percentage of the patients/residents in these institutions are so severely handicapped that they can neither judge whether they are getting quality services nor be in a position to advocate for themselves.
>
> Many state hospital patients/residents are profoundly dependent upon the system in which they live. They suffer from serious mental deficits which impair their ability to cope with the world around them. They often lack a strong network of interested family and friends outside the hospital, and their lack of financial resources deprives them of 'consumer clout' that is found elsewhere in a competitive economic system. In the best of circumstances this kind of dependency diminishes their ability to challenge the service being provided. These patients/residents are not able, by themselves, to provide the usual consumer pressures that motivate continual change and improvement.
>
> Even where there are interested outsiders--relatives or friends who visit often and try to be helpful--it is difficult for these people to judge whether their loved ones are receiving effective treatment, adequate physical care, or are being neglected. These outsiders need assistance in becoming educated observers and effective spokespersons.

(Emphasis added.)

10. Without clear programmatic standards and quality assurance, there is the continual threat of fiscal constraints overriding consumer needs (see Matson and Mulick, pp. 19-20) or at the very least, creating an imbalance in the system where provider needs, such as vacant beds, are conscious or unconscious factors in the placement process. This was noted by the State Hospital Mental Retardation Program Directors:

> Residential providers, in most cases, pressure the CWD and the state hospital staff for quick decisions and at times abrupt planning of discharges due to financial concerns eminating from vacant beds.
>
> Residential providers may in some cases pressure day program providers to accept state hospital residents for whom they are not equipped or ready to provide suitable programs.

Ex. 84, p. 2. As was candidly testified to by Mr. Ebacher, openings in facilities are often the impetus for placements including Mark's, and as noted by Mr. Anderson, to some extent Delores' as well. Ebacher Tr. 3/6/85, pp. 36-37; Anderson Tr. 1/11/85 (AM), pp. 229-230. At MLSH, Mark had been deemed "most appropriate for community placement", yet his placement prospects apparently did not materialize until Hearthside called. Ebacher, Id. and pp. 21-22. While there may or may not[50] be anything wrong with this process per se, it points out the necessity of having clear and enforced standards which ensure that placement decisions are based on the needs of the client.

11. Another pressure exists which originate in the Decree itself which is the unmistaken obligation of the Commissioner to reduce the population at the state hospitals to 1,850 by July 1, 1987. Paragraph 12. Through the issuance of bulletins, he has clearly instructed counties of their role and obligation in reducing the population at the state hospitals. (Copies of the initial Instructional Bulletin 81-53, 7/20/81, and the most recent one, Informational Bulletin 85-17, 2/21/85, on this subject, are attached hereto as Appendices I and J, respectively.)

12. The Decree recognized the need to reduce the population at state hospitals through decreased admissions where possible (paragraph 16) as well as by discharge into placements which appropriately meet the needs of class members. Paragraph 24; Bruce L., p. 1.

13. The Department has been on target in meeting the population reduction requirements of paragraph 12 (see Court Monitor's Fifth Report to the Court, pp. 14-15) and should be commended. Whether, in its efforts to achieve that objective, more qualitative obligations under paragraph 24 have been overlooked cannot be determined with certainty. Two things are clear. First, the Department has had no problem in issuing clear standards regarding population reduction. Second, placements have been occurring not only at Hearthside but apparently elsewhere (see (F) (1) and (2) above) which while helping to achieve compliance with the quantitative standards in the Bulletins and ultimately in the Decree, fall short of requirements of paragraph 24. In short, the potential for or reality of non-compliance with paragraph 24 because of the pressure to meet the quantitative and more easily measurable portions of the Decree, provides further reason for the need for clear directives and standards on the qualitative side.

VI. ADEQUACY OF DHS' ACTIONS TO RESOLVE IDENTIFIED PROBLEMS

1. Much of the evidence reviewed herein has been addressed elsewhere to varying degrees. This issue, the Department's efforts to remedy what they acknowledged to be deficiencies, requires that their actions be recapitulated. It has been found that (1) class members Dan, Delores and Mark were discharged to a facility that has not been able to appropriately meet their needs, (2) that mechanisms under the control or supervision of DHS (e.g., licensing, case management), whether viewed as preventative or reactive problem solving agents, have not functioned adequately and have thus contributed to the problem or have not been effective in bringing about a solution. Furthermore, while initiation of good faith efforts is not a defense to non-compliance (see Welsch v. Likins, supra, Memorandum Findings . . . (October 1, 1974), p. 33), an examination focusing primarily on what plaintiffs characterize as the "central office's" efforts is relevant and material with respect to:

-- one of the defendants' principle defenses that the class members' programs at Hearthside have improved and will continue to improve to a standard which will satisfy the Decree, due to the combined and cooperative efforts of the Department, Hearthside, and St. Louis County case management;

-- plaintiffs' argument that the Commissioner's efforts, once put on notice and having acknowledged the deficiencies, have not been adequate or consistent with his obligation to ensure that class members' rights are protected under the Decree[51]; and

-- determining the nature and scope of the recommendations.

2. One day after receiving plaintiffs' fifteen-page report, the Court Monitor, on November 1, 1983, wrote to Commissioner Levine requesting that he ask county personnel to review the allegations, both with regard to their accuracy and whether there were any omissions. Ex. 1, pp. 1-15. Dr. Wray wrote to Commissioner Levine again on November 29, 1983 reminding him of the previous correspondence and referring to two other investigations and reports from plaintiffs' counsel concerning another residential facility and day program in St. Louis County. Ex. 4, p. 21.

3. Plaintiffs' proposed findings 2.13-2.132 and 2.34-2.41 detail various responses, counter-responses, meetings, and actions by the Department, the county, and to some extent the Monitor and plaintiffs from that point, up to, and in one case (plaintiffs' proposed findings 2.41), shortly after the Notice was issued.

4. On December 8, 1983, a letter went out under Deputy Commissioner Giberson's signature to the county asking for an assessment of plaintiffs' allegations. Ex. 5; Bock Tr. 1/23/85 (PM), p. 19.

5. On December 19, 1983, the county responded by letter and memorandum, generally concurring with plaintiffs' observations and comments. Ex. 8.

6. During this period, Dr. Amado was retained by Dr. Bock as a consultant to the Department to assist in responding to issues posed by the Welsch case and to help in the development of

a Welsch compliance plan. Bock Tr. 1/25/85 (PM), p. 99. Dr. Amado was also assigned several responsibilities with regard to Hearthside. Plaintiffs' proposed findings 2.23. After examining plaintiffs' counsel's and the county's material to include records of the then two class members at Hearthside, he recommended that strong remedial measures be taken toward Hearthside and St. Louis County case management. This was contained in a memorandum to Bock on January 17, 1984. Ex. 117, pp. 6-7.

7. Dr. Amado along with licensing examiner Chilberg then undertook a licensing site visit to Hearthside in February and reported back their findings to Division personnel. The uncontradicted testimony shows that Dr. Amado reported to Dr. Bock that concerns originally identified in his January memorandum were confirmed based on his visit. Amado Tr. 1/25/85 (PM), pp. 115-120. Mr. Chilberg reported the findings and conclusions made by him and Dr. Amado in a March 6, 1984 memorandum to his supervisor. Ex. 53; Chilberg Tr. 1/25/85 AM, p. 55.

8. Finally, in April 1984, the Department appears to have undertaken its first remedial action which consisted of (1) an April 12, letter to Mr. Abrahamson from Mr. Chilberg requesting correction of deficiencies by August 1, 1984 which Chilberg/Amado had found on their February 1984 visit (Ex. 54); and (2) a phone conversation between Ms. Kudla and Ms. Takala concerning case management responsibilities (Kudla Tr. 12/21/84 (AM), pp. 55-61). The latter did not result in any follow-up action as Ms. Kudla had determined from this phone conversation that the county workers understood their responsibilities. Id. This was contrary to Amado's earlier analysis. Ex. 117, pp. 6-7.

9. The above-mentioned April 12 licensing letter directed to Hearthside was relatively comprehensive in its recitation of deficiencies and in accord with plaintiffs' original findings. What was noticeably absent was any real direction or guidance to Hearthside as to how it should go about correcting the deficiencies, however, it did say that a Mental Retardation Division consultant would be made available to assist the facility in complying with Rule 34. Ex. 54, p. 21. Beyond that, it merely requested correction by August 1, 1984. Id. This letter, as with subsequent actions taken by the Department, although perhaps more demonstrably so, represents an unfounded presumption on the part of the defendants, as plaintiffs point out, quoting Dr. Amado, "that by simply asking for technical adequacy from Hearthside . . . they will respond with state of the art services . . . ." Ex. 117, p. 6.

10. The letter also indicated that another licensing review would be undertaken in July 1984. Id. Three things can be noted about the aftermath of the April letter. First, there is no evidence that the Department ever assigned a mental retardation consultant to Hearthside for the purposes of assisting it to achieve compliance with Rule 34. Second, Mr. Abrahamson did respond by three separate letters indicating that Hearthside was making corrections. Exs. 54, 57, and 58. Third, Mr. Chilberg did return in July and was accompanied by Mr. Nord for a licensing review. Plaintiffs' proposed findings 2.44. This was Nord's first visit to Hearthside. Their visit was just two weeks shy of the August 1 compliance deadline yet they noted that major

deficiencies remained. See also plaintiffs' proposed findings 2.44.

11. Messrs. Nord and Chilberg returned to Hearthside on November 24, and Mr. Chilberg returned again alone on December 11, 1984. These appeared to be hybrid reviews for licensing purposes as well as to specifically review program plans of the class members. Plaintiffs' proposed findings 2.48. As discussed more fully in Parts III and IV, both individuals reported that deficiencies remained although improvement continued. Mr. Nord also prepared a memorandum which was attached to a December 12, 1984 letter from defendants' to plaintiffs' counsel and the Court Monitor. Ex. 32, pp. 122-124. Many of the recommendations in that plan were incorporated into the February 22, 1985 licensing letter.

12. The said February 22 licensing letter to Hearthside (Ex. 59) continues the same refrain, noting some improvement but acknowledging and seeking correction on major programmatic and staffing deficiencies at Hearthside, as more fully discussed in Parts III and IV, supra. It was sent six months after the compliance deadline of August 1, 1984 which the Department had imposed in the April 1984 licensing letter and over one year from the time when Dr. Amado indicated that strong licensing action should be taken.

13. With respect to case management, the record shows that after the Kudla-Takala phone conversation of April 5, 1984, no one from central office contacted Ms. Takala as to what actions should be taken by county case management with regard to

programs provided to class members at Hearthside. Plaintiffs' proposed findings 2.50; defendants' proposed findings 149.

14. Contact was not renewed until Assistant Commissioner (and the then Welsch compliance officer) John Clawson sent a letter on March 1, 1985 to St. Louis County. However, the letter merely recites and requests that the county case management monitor the IHP of every resident at Hearthside against the requirements of Rule 185. Ex. 60, p. 1-2. Ample testimony was provided that the county understood that Rule 185 was the governing rule for case management; unfortunately, the record also reflects a lack of true understanding as to how to properly carry out these duties. Nevertheless, the Clawson letter only states that two days of training and consultation "will be made available." Merely stating St. Louis County's obligation under law and making available two days of training is hardly responsive considering the scope of the problem as Dr. Amado pointed out and as the oral and documentary record reflects. This is particularly so given the overwhelmingly importance the Department itself places on county case management both legally and practically in assuring adequate service delivery. See for example defendants' proposed findings 146-148, 170, 172 and Part V(D)(2)-(4).

15. Additionally, the Clawson letter does not require that progress reports be made by the county on its efforts to monitor Hearthside, and more importantly, on how Hearthside is in fact coming into compliance with the IHP requirements of Rule 185.

16. The Department's pursuance of correction through licensing and case management are logical choices given that in Minnesota these are the two primary mechanisms to assure provision of quality services. However, the actual initiatives have been woefully inadequate.

17. In facilitating or requiring improvement of St. Louis County case management so that they may be both more effective in providing and monitoring services to class members, the record shows that the efforts have been all but non-existent. Over a period of 18 months, it has consisted of Ms. Takala's participation in a site visit with Dr. Amado and Mr. Chilberg, which the record shows, yielded minimal benefit, a telephone conversation between Ms. Kudla and Ms. Takala, and the March 1, 1985 Clawson letter citing obligations under Rule 185, and making available two days of training.

18. Up to February 1985, the licensing efforts directed at Hearthside offered little more. While the April 1984 licensing letter at least detailed the deficiencies at Hearthside (something which never had occurred with respect to case management), it did nothing more than request compliance and make available a mental retardation consultant which apparently never materialized.

19. The first time slightly more comprehensive approaches began to take shape was with Mr. Nord's December 1984 plan of correction. However, that plan was not revealed to Hearthside until late February when portions of it emerged as part of the February 22, 1985 licensing letter. Indeed, despite the purported action plan of December 12 and even the February 22

licensing letter, no one from the Department was at Hearthside from December 12 to March 15, the last hearing day. Abrahamson Tr. 3/15/85, p. 95. Based on the February 22 letter, Hearthside's license was extended from March 1, 1985 to October 1, 1985. Ex. 59. The license had been extended on a month to month basis since August 1984. Ex. 59, p. 1; Chilberg Tr. 1/25/85 (AM), pp. 25-27.

20. These last two actions, undertaken in late February and early March 1985 by Assistant Commissioners Sandberg and Clawson, respectively, no doubt represent good faith efforts on the part of the Department to address the needs of Welsch class members as well as other clients at Hearthside. Because these were undertaken and made part of the record just prior to the close of the hearings, their impact cannot be fully evaluated in the same way the Department's previous actions have; however several points can be made.

21. First, as stated above, the Department's initiative with respect to case management are, on their face, inadequate.

22. Second, the Department is still expecting Hearthside to resolve many of the major programmatic deficiencies cited in the February 1985 letter by itself despite Hearthside's limited resources. See Ex. 59, §§ 1(b), 2(b), 3(b), 4(b), 7(b). See also (1)-(4) on pp. 8-9.

23. Third, while several workshops were recommended for staff (Ex. 59, p. 6) which were in varying states of implementation on the last hearing date (defendants' proposed findings 204, 206, and 207), they would not appear to meet the need. The scope

and nature of the deficiencies are such that they do not appear soluble with a few workshops. More comprehensive and formal in-service with substantial follow-up and feedback on-the-job is needed, in accordance with basic training and management practices.

24. Fourth, the other corrective action which called for Mary Kudla to evaluate staffing to determine whether or not adjustments of shifts and schedules can enrich staffing ratios, has apparently yielded no results. See Dept. Ex. 14; Court Monitor's Ex. S; Hearthside's and plaintiffs' counsels' letters to Court Monitor of July 2 and 8, 1985, respectively. Thus, deficiencies in staffing, an area absolutely essential for the adequate development and implementation of each component of the IHP, continues to remain a major problem in terms of numbers, training, and supervision.

25. Finally, failure to address the per diem question, the standards issue and the discharge process have also inhibited or prevented, entirely, the solution to these other problems. See Parts IV(C) and V.

26. In sum, the Department's belated efforts are not adequate, and even if fully carried out, are not likely to ensure that Hearthside's and St. Louis County's case management will appropriately provide for the individual needs of the Welsch class members. It is therefore found that the defendants have not overcome the justifiably difficult burden of demonstrating that further intervention is unnecessary.

VII. SUMMARY

1. In order to appropriately meet the individual needs of class members an IHP must be properly developed and implemented. The basic components of an adequate IHP are set forth in Part II(D) and summarized in Appendix A.

2. From the time of their placement at Hearthside to the present, class members Dan, Mark, and Delores have not been provided a residential placement which appropriately meets their individual needs because adequate IHP's were not developed and implemented for them.

3. The chief reason for this fact is that Hearthside does not have a sufficient number of adequately trained and supervised staff to perform these critical functions.

4. Contributing factors also include Hearthside's own lack of resources and its inability to obtain an increase in its per diem, inadequate case management and licensing efforts, and a lack of clearly articulated and enforced directives or standards setting forth what is required for IHP development and implementation and staffing to ensure that a placement appropriately meets the individual needs of class members.

5. The Commissioner and his subordinates have, in fact, failed to comply with paragraphs 1 and 24 of the Decree because they failed to develop and/or enforce existing standards to be followed in the placement and monitoring of placements of Welsch class members which include at a minimum standards for development and implementation of IHP's which appropriately meet class members' individual needs and standards to be applied in determining whether a sufficient number of adequately trained and

supervised staff are provided to ensure such IHP development and implementation.

6. The need for such directives/standards is evidence by

-- the serious deficiencies which exist in the development and implementation of IHP's at Hearthside;

-- the inadequacies in the discharge process, case management, licensing, and the Department's central office's direct efforts to ensure that IHP's of class members are adequately developed and implemented;

-- the confusion or lack of knowledge of government personnel and private providers as to what is required to ensure that a placement appropriately meets the needs of class members;

-- the fact that none of the above issues are unique, and in fact apply to other class members, facilities, and county case management agencies;

-- the potential or actual imbalances that may arise or have arisen which subordinate class members' needs to other factors and considerations which, as discussed, may include county utilization rates of state hospitals or the fiscal concerns of providers. Part V(F)(9)-(13).

7. The Department in refusing or failing to develop and/or adequately enforce existing standards has contributed to a condition which tolerates and sanctions placements which are

substandard and allows discharge decisions to be made based on whether or not a class member might be better off as opposed to whether a potential service array will fit his/her individual needs. One of the reasons the defendants have offered for not wanting to develop standards for class members is that they do not want to create a "dual class" system, one for Welsch class members and the other for persons with mental retardation generally. Bock Tr. 1/23/85 (PM), pp. 123-124. The rationale offered is somewhat questionable since Welsch incorporates, directly or indirectly, much of the substantive state standards governing habilitation and services as well as some of the administrative mechanisms under the CSSA, a position taken by the position of the defendants in Bruce L. Id. at 4-5.

8. Very likely because of that, as plaintiffs point out, defendants only have needed to enforce existing standards. In any event, there must be clear standards to be followed in the discharge and monitoring of placements of Welsch class members because like any other litigants, they are entitled to what they bargained for in a consent decree.

9. Thus, even irrespective of the Commissioner's legal obligation at the inception of the Decree, the record demonstrates that to remedy the non-compliance found herein the issuance or enforcement of such standards is needed and appropriate.

10. The Commissioner and his subordinates have also failed to comply with paragraphs 1 and 24 because they failed to take prompt and effective action to ensure that class members were provided a residential placement which appropriately met

their individual needs as more fully described in Part VI, supra, including but not limited to:

a. Licensing action which promptly and effectively should have led to the correction of the deficiencies so long as class members were to remain at Hearthside;

b. Provision of adequate technical assistance and training for Hearthside staff and county case management staff so long as the two and then three class members were to remain at Hearthside and/or receive case management services from St. Louis County;

c. Undertaking all best efforts to assist Hearthside in obtaining adequate resources;

d. Or alternatively, undertaking all best efforts to provide for other community placements for the class members which would appropriately meet their individual needs.[52]

e. Providing relevant information in DHS' possession about Hearthside to the state hospital, and in particular the April 1984 Licensing Division report (Ex. 54) which was relevant to Hearthside's ability to appropriately provide for the needs of class members, in general, and which could have been used in the discharge planning for Delores which occurred four and five months later.

VIII. RECOMMENDATIONS

1. The Commissioner should develop by March 1, 1986 a Statement of Standards to be Followed in the Discharge, Placement, and Monitoring of Placements of Welsch Class Members which includes at a minimum

a. standards for development and implementation of IHP's consistent with the foregoing Findings, and,

b. standards which are to be applied in determining whether staffing is adequate to ensure development and implementation of an IHP, and each component thereof, which appropriately meets a class member's individual needs. Such standards shall include criteria for determining whether there are a sufficient number of staff, whether they are adequately trained, and whether they are adequately supervised.

The Statement of Standards should be submitted to counsel for the plaintiffs and to the Court Monitor for approval before being issued.

2. The Commissioner should forthwith direct state hospital and county personnel that no placement of Welsch class members (including those persons already in community placement) may be made at Hearthside Homes until

a. notice has been given to the Court Monitor

(1) by the Director of the Licensing Division of the Department of Human Services that all corrective action required in the licensing letter of February 22, 1985 (Ex. 59) has been taken, and,

(2) by the Director of the Mental Retardation Division of the Department of Human Services that the program

provided at that facility meets the Statement of Standards developed pursuant to paragraph 1, or,

b. an Action Plan has been developed after consultation with all parties and the Court Monitor has determined that the individual needs of the class member proposed to be placed are reasonably likely to be met at Hearthside.

3. By March 1, 1986, a review should be made, at the Department of Human Services' expense, of the Individual Service Plan (ISP), the IHP and the Hearthside and East Range DAC programs for each Welsch class member at Hearthside by a person or persons with training and experience which includes development of communications and vocational programs for persons with mental retardation. This person(s) proposed to do this review should be subject to approval by the Court Monitor after consultation with counsel. This person(s) and appropriate personnel from the Department should develop an Action Plan stating actions necessary either to ensure adequate development and implementation at Hearthside of an IHP for each class member or, if found necessary, to provide an alternative community placement for the class member. In either case, the Action Plan should be developed in accordance with the Statement of Standards; and in the instance of the former, due consideration should be given to all factors which have been identified herein which have caused or prevented Hearthside from being able to appropriately meet the individual needs of each class member. These include, but are not limited to, deficiencies in each component of IHP development and implementation, insufficient numbers of personnel, and

inadequate staff training and supervision in accordance with sound training and management practices, lack of resources, and size[53], setting, and location of the facility. This Action Plan should be submitted to the Department, the county agency, the family, Hearthside, and counsel for the plaintiffs for review and to the Court Monitor for approval.

4. A person from the Mental Retardation Division of the Department of Human Services shall be designated to review on site compliance with this Action Plan every two months for at least six months. That person should report promptly in writing to the Court Monitor and to counsel for the parties the extent to which the Action Plan has been implemented. He/she shall be accompanied on the last review by the person(s) designated in paragraph 3 and his/her findings should also be included in the report. This report should include copies of current programs at both the residential and day program, copies of program data, and copies of program evaluations.

5. The Commissioner should designate a person or persons from within the Mental Retardation Division of the Department of Human Services or retain such qualified persons to review within the next six months the ISP, the IHP, and the residential and day programs of all Welsch class members

a. receiving case management services from the St. Louis County Social Services Department, and,

b. residing in residential facilities with a per diem of $45.00 or less

to determine in accordance with the Statement of Standards whether the class member is being provided an IHP which

appropriately meets his/her individual needs. A summary of the findings made should be submitted monthly to the Court Monitor and counsel for the plaintiffs. In the event that a determination is made that the class member is not being provided an appropriate IHP, an Action Plan should be developed in a manner consistent with paragraph 3, above, and monitored in a manner consistent with paragraph 4, above.

6. The Commissioner should by March 15, 1986, issue an Instructional Bulletin to all county agencies and state hospitals (copies should be provided to community-based providers of services to persons with mental retardation) with which should be included a copy of the Statement of Standards. In this Bulletin the Commissioner should:

a. Direct state hospital and county personnel not to place a class member in any residential placement which does not meet the staffing portion of the Statement of Standards.

b. Direct state hospital and county personnel not to place any class member in any residential placement which does not meet that portion of the Statement of Standards regarding the development and implementation of IHP's unless an Action Plan is developed and agreed to by the provider, the county agency, and the state hospital discharge team which indicates the steps which the parties to the Action Plan will take to assure that programmatic standards will be met within thirty days of discharge. Before a class member is discharged from a state hospital in accordance with this Action Plan procedure, a statement of the deficiencies in the residential program and the proposed Action

Plan should be submitted to the Director of the Mental Retardation Division or to a person(s) within the Mental Retardation Division designated by him for approval and a copy should be sent to the Court Monitor. Implementation of that Action Plan should be monitored in a manner consistent with paragraph 4, above.

c. Direct county agency personnel on the discharge planning team to provide discharge team members at least three working days prior to the discharge planning meeting with

(1) a representative two-week staffing schedule for the residential provider which should include information about the training and experience of direct care staff and the training and experience of supervisory and professional staff together with the numbers and degree of handicap of the residents of the building or unit in which the class member would live, and,

(2) a detailed report on the assessment and goal selection processes used in development of IHP's at the proposed residential placement, and,

(3) examples of the types of programs implemented at the facility, the program data maintained, and the program evaluation processes used, and,

(4) the class member's current ISP, and

(5) a report on the current status of ICF/MR certification and Rule 34 and any other licensure together with copies of any publicly available written documents, reports, or letters prepared within the past year by either the Department of Health or the Licensing Division of the Department of Human Services stating deficiencies in the facility.

d. Direct state hospital and county agency personnel involved in the discharge planning process that the fact that a facility may have ICF/MR certification and a Rule 34 and any other licensure does not relieve the discharge planning team of the responsibility to make an independent determination whether the facility meets the staffing and IHP provisions in the Statement of Standards.

e. Establish a procedure which allows any person participating on or entitled to participate on the discharge team to request review prior to the discharge of the determination by the team that a proposed placement meets the Statement of Standards by a person(s) designated by the Director of Mental Retardation Division of the Department of Human Services. The Court Monitor and counsel for the plaintiffs should be notified forthwith of any such request for review. The final decision whether or not a proposed placement meets the Statement of Standards should be made by the Director of the Mental Retardation Division or his designee.

f. Direct county agency personnel to monitor the appropriateness of all Welsch class members' placements on the basis of the Statement of Standards on a quarterly basis and, in the event that a determination is made that a class member's IHP does not comport with these standards, direct the county agency a) to require the provider to take necessary corrective action, and b) to report promptly to the Commissioner (1) the basis for the determination that a class member's IHP did not comport with these standards, and, (2) the corrective action already taken, and, (3) any needs of the county agency or the provider that

should be met to enable either or both of them to appropriately meet the individual needs of class members, e.g., additional staff, training, or technical assistance. The Commissioner should provide copies of all such reports and the responses made by the Commissioner to the Court Monitor and to counsel for the plaintiffs on a monthly basis.

7. The Licensing Division of the Department of Human Services should provide the Chief Executive Officer and the Director of Social Services or senior social worker at each state hospital with copies of all licensing letters of the type exemplified by Exhibits 50, 54, and 59 and all notices of adverse licensing action for all residential facilities in the state serving persons with mental retardation prepared within the past year and, on an ongoing basis, in the future. The Commissioner should seek the cooperation of the Department of Health to arrange for comparable information to be provided to state hospitals from that agency.

8. The Commissioner should report to the Court Monitor by February 15, 1986:

a. The circumstances under which information obtained by the Licensing Division which is relevant to the determination whether a present or proposed placement comports with the Statement of Standards but is not yet incorporated in a formal licensing letter may or may not be disclosed to state hospital and county agency personnel.

b. Whether the eleven licensing positions requested in the last Legislative session were obtained, and whether there

are any current or future plans to request additional licensing positions from the Legislature, and if so, how many and for what purpose.

c. The status of any application made by Hearthside for additional funds under Rule 186 or the pass through provisions of Rule 53 (see Appendix F, p. 755).

d. Current or future plans to request the Legislature to remove or otherwise address the rate reimbursement cap on residential facilities.

Further recommendations will await receipt of this information.

9. The cost of the transcripts for the hearing should be borne by the parties in accordance with applicable federal statutes or rules. If agreement cannot be reached, then the matter should be brought to the Court's attention in a timely manner by joint or separate motion of the parties.

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January 22, 1986
Dated

Richard A. Cohen
Court Monitor

cc. Leonard W. Levine, Commissioner
Luther Granquist, Esquire
Deborah Huskins, Esquire
Jeffrey Stephenson, Esquire

NOTES

1. Plaintiffs submitted six volumes of exhibits. The exhibits are numbered 1 through 120, although there are gaps in their numbering sequence. References to Ex. 1, Ex. 2, etc. will be to plaintiffs' exhibits. Department exhibits are identified as Dept. Ex. 1 (etc.) while the Monitor's are designated by letter, e.g., Court Monitor's Ex. A. Transcript references are generally by the name of the witness, date and page, and by (AM) or (PM) when transcripts were separately prepared for morning and afternoon sessions.

2. The notice also referred to certain texts, treatises, and standards. Court Monitor's Ex. D, pp. 3-4.

3. In a September 30, 1985 letter, Hearthside's counsel offered a May 15, 1985 Memorandum by R. Chilberg to W. Fink, entitled "Quick Response to Mary Kudla's Letter." Mr. Chilberg had testified in the proceeding. Ms. Kudla's letter, Dept. Ex. 14, was introduced by the defendants after the hearing and accepted into evidence. Neither plaintiffs nor defendants objected to the Chilberg memorandum and it is hereby accepted into evidence as Court Monitor's Ex. S, along with Hearthside Counsel's cover letter which is marked as Court Monitor's Ex. T.

4. However, an IHP may very likely have several goals and objectives in these domains to increase, for example, skills for emergency evacuation, manner of eating or self-feeding, and/or self-administration of medication. See Kudla Tr. 12/21/84 (AM), p. 72 and Part II(C)(3) and (D), infra.

5. When courts have fully reached the question of what is minimally required to ensure adequate treatment the development and implementation of the IHP has been considered an essential feature. Given the posture of the instant proceeding, it is ironic that Welsch v. Likins, 373 F.Supp. 487 (D. Mn. 1974), along with Wyatt v. Stickney, 344 F.Supp. 373, 379-386, (M. D. Ala. 1972), are frequently cited as the leading cases in establishing the minimal criteria of habilitation. See Herr, S., Rights and Advocacy for Retarded People, Lexington Press (1983), p. 42. In so doing, this Court relied heavily on Rule 34 standards and ICF/MR regulations (see, e.g., Welsch v. Likins, No. 4-72 Civ. 451 Memorandum Findings . . . (October 1, 1974), App. A to said Findings, p. V), while the Wyatt Court relied on ACMRDD standards. Wyatt supra at 406. Rule 34/ICF/MR standards are generally considered minimal standards. See note 11. However, as will be discussed infra, since the requirements of these "minimal" standards approximate if not encompass the requirements of paragraph 24 of the Decree, defendants' argument may be moot. See also HHS Dept. Grant Appeals Board Decision, Re: Connecticut Dept. of Income Maintenance, Docket No. 83-125, Dec. No. 562 (8/17/84), pp. 10-12, Appendix E to these Findings.

6. Adjudications in other cases are unhelpful. Defendants in signing the Decree neither conceded liability (see paragraph 110 of the Decree) nor acknowledged specific legal rights of plaintiffs. See also Fox v. United States Dept. of Housing, Etc., 680 F.2d 315, 319 (3rd 1982). There was likewise no adjudication of the potential scope of rights and remedies. The inquiry is solely what the parties intended as seen through the language of the Decree. As stated in United States v. Armour, supra at 681-682:

> Consent decrees are entered into by parties to a case after careful negotiation has produced agreement on their precise terms. The parties waive their right to litigate the issues involved in the case and thus save themselves the time, expense, and inevitable risk of litigation. Naturally, the agreement reached normally embodies a compromise; in exchange for the saving of cost and elimination of risk, the parties each give up something they might have won had they proceeded with the litigation. Thus the decree itself cannot be said to have a purpose; rather the parties have purposes generally opposed to each other, and the resultant decree embodies as much of those opposing purposes as the respective parties have the bargaining power and skill to achieve. For these reasons, the scope of a consent decree must be discerned within its four corners, and not by reference to what might satisfy the purposes of one of the parties to it.

(Emphasis added.) This case certainly fits that mold. Negotiations began after the presentation of the plaintiffs' case at trial in 1980 and prior to the presentation of the defendants. A review of the various drafts of the decree (see Bruce L., pp. 4-5) reveals that negotiations were dynamic and complex and a number of changes were made, some of which are material to the issues in this proceeding. Whether either party could have gotten less or more if the adjudication continued is purely speculative at this point. Each side obviously evaluated the risks and other factors with which it was concerned during negotiations and entered into a binding contract -- a consent decree.

7. See Ex. 31, pp. 114-116. Plaintiffs actually proposed several of the changes themselves based on the record of the case as it developed. Plaintiffs' memorandum, p. 8 and proposed findings 4.43, 4.45.

8. The term Individual Program Plan (IPP) is used interchangeably with Individual Habilitation Plan (IHP). A later version of Rule 185 substituted the term IHP for IPP. Ex. 70, p. 3, subp. 16. See also Department's Six Year Plan for the Mentally Retarded, August 1980, Appendix B, p. 48 which confirms this point.

9. Paragraph 63 explicitly requires that each class member in the state hospitals be provided an IHP and "programs of training and remedial services as specified in Department of Public Welfare Rule 34 . . . ." While paragraph 24 does not contain such an explicit incorporation, possibly due to the wider variety of licensing rules applicable in the community, it would be anomalous indeed if class members were afforded less protection when placed in the community as part of the population reduction requirements of the Decree. See N.Y.S.A.R.C. v. Carey, 492 F.Supp 1099. 1108 (E.D.W.Y. 1980). In any event, an equivalent protection is afforded by, among other things, the requirement of an IHP consistent with Rule 185, as well as the mandate of paragraph 24.

10. There have been three versions of Rule 185 in effect since September 1980. The first is in the record as Dept. Ex. 4. A second version was adopted in February 1981 (Ex. 71) based on changes to the original that were being proposed while the Decree itself was being negotiated. See Proposed Amendments to Rule 185, 4 State Register 1973 (June 23, 1980) and Adoption of Amendments to Rule 185, 5 State Register 1263 (February 16, 1981). The third version, the current emergency rule, became effective on October 29, 1984 and is Ex. 70. While, as mentioned above, defendants argue that the 1980 version is the operative one, in order to determine the issues herein, it does not appear necessary to resolve the question of which version applies. The result would be the same. The defendants could not, in any event, nor have they, modified their rules in such a way to provide less protection to class members. See Cornelius v. Hogan, 663, F. 2d 330 (1st Cir. 1981).

11. It should also be pointed out that Rule 34 and ICF/MR regulations, because of their licensing and funding certification functions, are considered only minimal standards (Ex. 86, 4th page, "Purpose"; Court Monitor's Ex. A, pp. 2-3; Gardner, J. et al. (Eds.), Program Issues in Developmental Disabilities--A Resource Manual for Surveyors and Reviewers. Paul H. Brookes Publishing Co. 1980, p. 150) which may explain why the parties apparently did not make them the exclusive source for determining the adequacy of a community placement or IHP. See Deposition of Deputy Commissioner Giberson, Ex. 77, p. 8. In fact, the Department itself has been critical of these rules, particularly as they have been applied. Court Monitor's Ex. A, pp. 1-2. Nevertheless, the direct and indirect references to them in the Decree evince a clear intent that they are to be considered and applied.

12. DHS personnel have also used Rules 185 and 34 and the ICF/MR regulations virtually exclusively as the standards to assess whether class members' needs are being appropriately met (see, e.g., Kudla Tr. 12/21/84 (AM), pp. 65, 81; Nord Tr. 1/23/85 (AM), pp. 74-76; Bock Tr. 1/23/85 (PM), pp. 9, 22, 45, 127; Chilberg Tr. 1/25/85 (AM), pp. 47-48; see also Giberson Deposition, Ex. 77, p. 8), although as a legal

matter in a proceeding such as this one, DHS does not concede that strict compliance with those standards is required. See also Part V(B), infra.

13. In 1977, HEW published interpretive guidelines to ICF/MR regulations, and in 1982, published another set of guidelines to be used for ICF/MR facilities serving 15 or fewer persons. Both sets are appended hereto as Appendices C and D, respectively. While there are no major differences between the sets, both are furnished and referred to because even though Hearthside is a facility having more than 15 persons, the 1982 guidelines may have more applicability. The differences in the later guidelines reflect the fact that smaller facilities, which are generally community-based, must and should rely on outside resources in providing services. Appendix D, pp. 415-417. While Hearthside might technically fall under the 1977 guidelines, it has many of the characteristics of a smaller facility as, for example, it relies on outside resources to supplement its efforts. For purposes of the issues herein, and also because these are interpretive guidelines (see Appendix C, p. 265), it is not necessary to decide which set is applicable. Additional guidance in interpreting the intent of the ICF/MR regulations, particularly with respect to the issues in this proceeding, are contained in two additional sources: (1) an HHS Departmental Grant Appeals Decision Re: Connecticut Dept. of Income Maintenance (8/17/84) (attached as Appendix E), which appears to be the only published administrative decision on the requirements of the Active Treatment/habilitation provisions of the ICF/MR regulations; and (2) Gardner, J. et al. (Eds.), Program Issues in Developmental Disabilities--A Resource Manual for Surveyors and Reviewers. Baltimore: Paul H. Brookes Pub. Co., 1980 (hereinafter sometimes referred to as "Program Issues . . . Resource Manual for Surveyors and Reviewers") noticed in Court Monitor's Ex. D, p. 3 and which is cited frequently in the 1982 interpretive guidelines (see, e.g., App. D, p. 418), as well as in the HHS decision, pp. 584-585.

14. Court Monitor's Exs. A, G-I, K, and L.

15. See in particular Court Monitor's Ex. D, p. 3, e.g., II(A),(B),(D), and (E).

16. This is not to exclude persons who may be labeled as mildly retarded, particularly if they have other handicaps or problem behaviors.

17. This perhaps explains why both the Decree, indirectly and directly, and Rule 185 place such heavy reliance on ICF/MR and Rule 34 standards. The ICF/MR program was the predominant model of programming for the vast majority of all mentally retarded persons being served. While this was to change slightly with the implementation of the Six Year Plan with the expansion of the Semi-Independent Living program

(SILS) for class members, it was the intention at least in the defendants' mind that the ICF/MR facilities would be the predominant mode of placement for class members.

18. Over or exclusive reliance on this part of the process can, in fact, prove to be detrimental. Program Issues . . ., pp. 129-131; see also Matson and Mulick, pp. 217-218.

19. As stated above, the 1980 version of Rule 185 was specific in setting forth the requirement of "goals" as it defined individual program plan as including "[a] detailed plan of the service provider setting forth both short-term and long-term goals with detailed methods for achieving movement toward the individual service plan of the local social service agency." Dept. Ex. 4, p. 346. Components of the "active treatment" and the individual written plan under the ICF/MR regulations, 42 CFR 435.1009 include both short and long-range goals which it states should be developed and "measured in terms of the individual's habilitation and progression from dependent to independent functioning." Appendix D, p. 419. See also the October 1984 Rule 185 Ex. 70, pp. 14, 19.

20. Defendants correctly point out that Rule 34 does not contain an explicit reference to teaching "methodologies." Defendant proposed finding 95. However, as stated above, HHS interpretive guidelines to the ICF/MR regulations do call for the prescription of specific methodologies. It is also interesting to note that when state personnel perform licensing reviews or hybrid Welsch licensing reviews, this component is included as one criterion. See Chilberg letter to Abrahamson, 4/12/84, Ex. 54, p. 19; Kudla Tr. 12/21/84 (AM), pp. 79-82; Ex. 74, p. 3; Ex. 75, p. 3; Ex. 76, p. 2.

21. Pursuant to the DHS Quality Assurance Plan for State Facilities (Court Monitor's Ex. G), program review teams were assembled and given the following charge: "[T]o evaluate the adequacy, appropriateness, and effectiveness of program efforts of state institutions for mentally retarded individuals . . . ." Program Review, Mental Retardation Program at Fergus Falls State Hospital and Cambridge State Hospital, October 1984, p. 2, Court Monitor's Ex. H. The teams consisted of 6 or 7 members, all but one of whom were mental retardation professionals from Minnesota. They developed the "review procedures" and included as one of their global as well as specific criteria, the existence [and effectiveness] of "written programs . . . to guide the efforts of staff in helping residents to learn" or which they also called "skill acquisition programs." Id. at 9-10.

22. Defendants' counsel's criticism that having standards violates the principle of individualization or the "individual needs", requirement of paragraph 24 (defendants' memorandum p. 30), mischaracterizes the role of standards. Aptly put in a recent publication edited by three distinguished pro-

fessionals, Paine, S., Bellamy, G. T., Wilcox, B. Human Services That Work. Baltimore: Brookes Publishing Co. (1984):

> "[T]here must be the articulation of a common service problem and a determination that it occurs frequently enough to warrant the development of a standardized solution. Though, at first glance, this emphasis on shared problems appears to counter the trend to personalizing services through individualized treatment and education programs, there is, in fact, no real conflict. Most human services are organized to serve clients who, while diverse in many ways, present common service needs. For example, the population of mentally retarded children is as diverse as the population of those who are not mentally retarded, but many children with mental retardation share the need for intensive education to develop self-help, social, or communication skills.
>
> . . .
>
> Each population is heterogeneous but differentiated by a set of service needs. Individualization occurs within those services, and can mean that different clients receiving the same service components receive them on different schedules, work on different skills within that component, or work under varying degrees or types of structure, supervision, external support, or motivation.

Id. at 30 (emphasis added). See also Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 68.

23. Plaintiffs' proposed standards did not initially contain an explicit reference to maintenance and generalization procedures. They have since requested that any such standards issued include them. Clearly, plaintiffs' initial version did not preclude their incorporation and indeed arguably were implicit in them.

24. Other policy considerations are served by reliable data collection and evaluation.

> Cost-conscious taxpayers and consumers concerned about rights to effective services have begun to ask in-depth questions concerning the results of programs. The commitment to measuring objectively the outcome of training programs is consistent with this concern and is the hallmark of a behavioral approach. It is the strongest guarantee that effective programs are being provided and is essential for consistent measurement of whether goals and objectives have been met. Systematic measure-

ment or analysis of the resident's behavior allows for changing ongoing treatment procedures as well as determining the overall effectiveness of the program.

Program Issues . . . Resource Manual for Surveyors and Reviewers, p. 88. See also Bernstein, et al., p. 103.

25. As will be discussed in Parts IV and V, some of the reasons for lack of improvement is attributable to the failure to address underlying problems such as lack of adequate staffing, low per diem, etc.

26. Even if the "better off" standard applied, the state of the record is such that it would not permit definitive findings and conclusions to be made respecting it. First and foremost, plaintiffs did not gear their factual presentation to this standard. While arguably some of the evidence they presented may have an incidental relationship to the "better off" standard, for the most part, they did not address it. Defendants are not similarly prejudiced. This is because plaintiffs' proposed standards and what the Monitor has adopted, closely approximates the standards and principles that the Department uses in determining licensing and general quality assurance compliance as well as Welsch compliance. See, e.g., Kudla Tr. 12/21/84 (AM), pp. 79-82; Ex. 74, p. 3; Ex. 75, p. 3; Ex. 76, p. 2. Defendants' proposed findings 198. While the defendants presented evidence which related to the "better off" standard, much of their factual case focused on the state or plaintiffs' similar standards. Plaintiffs were also clear in their December 10, 1984 pretrial statement as to the standards they thought were required by paragraphs 24 and 26 of the Decree and upon which Hearthside should be judged (Ex. 31, pp. 109, 114-116) and, as mentioned above, both during and prior to the emergence of Hearthside as an issue, they clearly articulated their position. The specifics of the defendants' standard, on the other hand, did not begin to unfold until after the hearing commenced and were not explicitly articulated until they presented their position in their post-hearing findings. While the Department prior to the hearing took the position that paragraph 24 incorporated "federal constitutional standards" (Ex. 23, p. 70), they neither indicated the source in the constitution nor the parameters of the rights or standards (Ex. 26, p. 95). Second, as discussed above, the testimony of progress defendants rely on lacks adequate substantiation.

27. The statement that Mark has adjusted well hardly supports another assertion contained in defendants' findings also relying on Jungwirth and Thoreson, namely: "Mark would have a hard time adjusting to any change of facilities. It took him a long time to adjust to Hearthside." Defendants' findings 116, p. 30, emphasis added.

28. There is no evidence of an intent to mislead or mischaracterize. In fact, the witnesses' testimony very likely reflect how they subjectively saw each client and the "progress" that they believe has been made. One need not be a psychologist, however, to understand that the reconstruction or the recollection of interested witnesses may often paint a glossier or different picture than what in fact might exist. This is, of course, why data is so important. See Part II(D)(5), Finding 5.5, citing Bernstein, et al., p. 102.

29. In reviewing the actual IHP, it in fact appears that there are no timeframes for long-range goals and no goals are identified clearly as yearly goals. Ex. 10, p. 25; Ex. 102, p. 12; Ex. 103, p. 14.

30. One thing is for certain that in one program which was characterized as being on maintenance status; namely, Mark's communication program, such a status would not be warranted. See plaintiffs' proposed findings 5.144.

31. There is a laundry program which, as it was originally conceived, in approximately January 1984, called for Mark using the laundromat in Tower once per week. Ex. 103, pp. 44-46. While the objective is poorly stated (and this is the case under the original program and under a revised and supposedly improved version, Id.), the programs at least require the activity to occur in a natural environment, and Mark does much better at the laundromat than in "laundry class." Id.; Jungwirth Tr. 12/20/84 (AM), p. 104. However, contrary to the written program Mark goes to the laundromat once per month, if that. Id.

32. This is not necessarily a reflection on Mr. Thoreson's and Ms. Jungwirth's abilities to acquire and apply skills in programming or data collection when given the appropriate opportunity and technical assistance. As discussed in more detail in Part IV(A), infra, adequate training must consist of more than classroom instruction, particularly where training is obtained only in one or two workshops.

33. Ms. Jungwirth described Hearthside as being apparently somewhat less restrictive than a state hospital but more restrictive than a group home or another setting in the community. Indeed she described it as "a steppingstone from state hospital to a group home and then on out in the community." Jungwirth Tr. 12/20/84 (AM), p. 211.

34. One of the deficiencies cited in Exhibit 59 is the lack of regular and frequent program implementation. As indicated in the text, while no systematic time-study evaluation was done by any of the witnesses, the cumulative evidence indicated a general lack of activity. The Monitor's view of Hearthside confirmed (see Welsch v. Likins, supra, Memorandum Findings . . . (October 1, 1974), p. 22) this fact

during the approximately one hour spent there. The vast majority of residents were congregated in large groups in several different rooms through several different buildings, either doing nothing at all or watching T.V. The other primary activity appeared to be afternoon baths. For a brief period of time several residents were engaged by one staff person in the use of coins. Two residents were observed in the craft area; one of whom was busy with a project. All three class members were observed and at the end of the view, Dan was seen carrying a basket of clothes toward the direction of the greenhouse.

35. This was the first of three papers the Governor's Planning Council on Developmental Disabilities published on staffing and personnel needs in the mental retardation field in Minnesota and was done pursuant to a requirement in the Developmental Disabilities Assistance and Bill of Rights Act, 42 USC 6009.

36. In contrast, the ACMRDD standards (1981) would at a "minimum" (p. 55) seem to prescribe 1 to 4 to 1 to 8 ratios of direct-care staff to residents for the characteristics of persons residing at Hearthside (ACMRDD Standards, p. 57) and a minimum of 1 to 4 for the second shift (Id.). See Kudla letter to Abrahamson, May 3, 1985, Dept. Ex. 14 which describes Hearthside's residents' characteristics. Dept. Ex. 14, p. 3, for client characteristics. It is interesting to compare the staffing at Hearthside with a relatively discrete unit of comparable size in the state hospital system. Minnesota Learning Center (MLC) also had a licensed capacity of 40 individuals. At MLC, residents are primarily higher functioning mentally retarded and non-mentally retarded adolescents with behavior problems. See Court Monitor's Fourth Report to the Court, p. 39. They would appear to have less needs intellectually and cognitively than residents residents at Hearthside, but might on the whole have more behavior problems. See Dept. Ex. 14, p. 3. While it is hardly an identical match up, it is of at least some significance to note that based on reports produced by MLC pursuant to the Welsch v. Levine Reporting Order, MLC has had 55 full-time equivalent positions as compared with 12 to 14 for Hearthside. Abrahamson Tr. 3/15/85, pp. 97-107, 114-115. The figures from MLC do not include cooks and perhaps other support staff (including indirect or direct assistance it receives from Brainerd State Hospital of which it is a part). The figures from Hearthside include everyone.

37. For the two fiscal years preceding the approval of the Decree (1979 and 1980), admissions averaged 206 per year. Court Monitor's Fifth Report to the Court, April 1985, p. 32.

38. A comparison of the six year plan(s) with the Decree, shows that some provisions of the plan were incorporated in the Decree expressly; some were not. The parties, for example,

did not expressly include the 400 new ICF/MR beds objective as the means the Department would be obligated to pursue under the Decree. On the other hand, the population reduction figures were taken from the plan (or vice versa). Some of the legislative proposals were taken from the plan. Compare objective eight (Appendix B-1, p. 147) on removing fiscal disincentives for counties to place mentally retarded people in community based facilities with paragraph 89(f). There are, likewise, community provisions in the Decree which do not have as their source, e.g., paragraph 88. The point is that the measures in the six year plan, some of which were incorporated in the Decree, some of which were not, demonstrate a recognition that change was needed.

39. Given the authority and obligation of the Commissioner under the CSSA and other statutes, to include 256E.045 (b), as well as his independent obligation under paragraph 1 of Welsch (see also Swenson v. State of Mn. Dept. of Welfare, 329 N.W. 2nd 320, 323, n.3), there is no necessity to join the County in this proceeding. See defendants' memorandum, pp. 40-41.

40. Rule 185 is theoretically an appropriate model because of its incorporation in and interrelationship with the Decree and because the IHP requirements stated in it are very similar to the requirements of paragraph 24. However, by the Department's own admission up to apparently this current version, it was never been fully enforced. Dept. Ex. 10, 2nd page; Ex. 38, February 19, 1985 Clawson Memorandum (p. 1) attached thereto. The lack of enforcement was de facto. Under the new October 1984 version, the lack of full enforcement has become almost de jure, as counties may obtain variances. See Instructional Bulletin 84-109 issued on December 12, 1984, attached hereto as Appendix H. As of February 19, 1985, many counties had already applied for variances. Ex. 38, supra. To what extent Rule 185 will be enforced even with variances, remains to be seen. Rule 185 also does not specifically address the question of staffing.

41. As stated previously, this case is now governed by a Consent Decree and not by an adjudication of rights, constitutional or otherwise. Part II(B)(4), supra.

42. This would violate paragraph 22(c) which, as discussed above, requires an IHP consistent with Rule 185, and indirectly Rule 34 and ICF/MR standards. See also David D. v. Dartmouth School Committee, Nos. 84-1937-39 (1st Civ. October 15, 1985) 9 MPD2R 450.

43. Ironically, the County, to include Ms. Takala, had been directly involved in the investigation of Hearthside in which staffing deficiencies were acknowledged by the County itself and by Licensing. Exs. 8, 53, and 54.

44. This is not to say that case managers should not look to Licensing for help in determining whether the facility as a whole is minimally adequate for safety or habilitative reasons, and that Licensing should not supply relevant information to placement personnel. In that latter vein, as discussed in Section E below, Licensing does not necessarily inform county or state hospital officials about deficiencies when they may be relevant to the ability of a facility to meet current or prospective class members' needs.

45. The above-referenced report is on file with the Court Monitor's office as well as with the defendants who furnished it.

46. CWD would seem to stand for County Welfare Department and would appear to be referring to case managers or social workers.

47. As the Department has indicated, the hiring of the Regional Service Specialists as well as the Case Management Specialist on the Department level will provide additional training and support, but see Court Monitor's Ex. K, p. 2 quoted above.

48. These findings should not be read to endorse what is frequently characterized as a regulatory, punitive approach to licensing. Good public policy and sound behavioral principles dictate a proactive, balanced approach to licensing/quality assurance. Bernstein et al., pp. 278-282. There has been a recognition in this state (Minnesota Model Standards, Ex. A, p. 2) and elsewhere (Bradley et al., Assessing and Enhancing the Quality of Services, A Guide for the Human Services Field, Human Research Institute, supported by a grant from the Office of Human Development Services, HHS, 1984, pp. 1-10) that a positive and proactive approach to quality assurance is needed to assure adequate services. This is an approach which rewards and promotes quality, provides technical assistance, and staff development to address weaknesses, and at the same time, does not compromise, and, in fact, promotes better adherance to quality standards of care and habilitation. Id. This is in contrast to a punitive-myopic, and non-program based approach which has been described as a pervasive problem in Minnesota (as elsewhere).

> Survey team members [Rule 34/ICF/MR licensors] typically do not have specialized expertise in mental retardation, program planning and resource development and thus, generally, are not able to assist the facility in resolving program weaknesses. Traditionally, the whole quality assurance process has been based on a punitive approach toward facility compliance rather than on strengthening program deficits and addressing resolution of those problems. Often it appears that

the quality assurance process acts to impede the progress of deinstitutionalization, despite repeated assertions by state and federal officials of their commitment to deinstitutionalization.

Court Monitor's Ex. A, p. 2.

49. Standard-setting and enforcement have been recognized as especially necessary and appropriate in a decentralized form government structure to ensure accountability. Hamilton and Hamilton, Governance of Public Enterprise. Lexington, Ma: Lexington Publishing Co., 1981, p. 55. It has been recognized as one of the essential features to a mental retardation service system generally (Matson and Mulick, p. 18) and to successful deinstitutionalization in particular. Scheerenberger, R. C. A Model for Deinstitutionalization, Mental Retardation (1974), 12, 3, 5-6.

50. This cuts against the spirit, if not the letter, of paragraph 21 of the Decree which presupposes that services will be developed or arranged based on an assessment of clients' needs, not on what is available.

51. In the long run, how well the system operates without the degree of prodding and scrutiny this matter has seen is also of overriding importance. How preventative a system is in its orientation no doubt will determine the overall quality and the quantity and nature of the complaints. Its reactive capability, through a responsive client protection system, for example, is also as important particularly given the vulnerable nature of many citizens with mental retardation (see Court Monitor's Ex. G, pp. 33-35), and because no matter how proactive or preventative case management, licensing or other quality assurance systems are, individual problems will arise and require address. See also plaintiffs' memorandum pp. 11-13.

52. If a new placement were now to be developed for any of the class members, family relationships should obviously be taken into account. See defendants' proposed findings 122 and 136. This would hopefully always be the case regardless of what prompts a move (e.g., need determination, least restrictive alternative determination). If movement is deemed necessary as a result of the recommendations in this proceeding, consideration could even be given to arranging or developing a residential placement closer to, for example, Dan or Delores' respective families. Id. If it is determined that a move, rather than remaining at Hearthside, will serve the interests of any of the class members, a family member should not be able to block it. This is the case as a matter of law as each class member is under state guardianship. Moreover, opposition frequently exists from family members when a discharge is being contemplated from an institution even ones acknowledged to be in a deplorable state. While there are many complex reasons for this, one

is the fear of the unknown and of the seeming lack of permanence to a "community setting" as opposed to an institution. Conroy, J. W. and Bradley, V. J., The Five Year Logitudinal Study of the Court-Ordered Deinstitutionalization of Pennhurst, Philadelphia: Temple University Developmental Disabilities Center. Boston: Human Services Research Institute (1985), pp. 186-190. Almost universally, when quality placements are made, family members' opinions dramatically change as the community placement becomes real and they see the benefits to a small home-like setting. Id. See also Welsch v. Levine, Court Monitor's Findings, Tamara S. (September 15, 1985), pp. 4-5.

53. While at this stage, no particular option is preferred over the other, the person(s) retained and the Department are encouraged to consider all creative but practical solutions to be incorporated in the Action Plan. As indicated in the Findings, the shortage of staff as contrasted with the substantial number of residents at Hearthside is a major problem. More staff could be provided directly to class members (e.g., through Rule 186 funds) or staffing ratios could be generally enriched for the facility (e.g., through Rule 53 pass through funding). Size reduction at Hearthside could be employed in such a way to accomplish this same end, i.e., enriched staffing. To reiterate, all reasonable option(s) designed to achieve compliance will be entertained. The size reduction possibility, while perhaps posing more practical and logistical problems which would have to be overcome, is surely more consistent with the state's statutory and public policy of home-like and normalized residences (see Part II(C)(3) and Mn. Stat. 252.28 and 252.291), and the preference expressed in paragraph 25 of the Decree for residences of 16 or less beds and/or units with 6 or less.

54. The Decree is silent on the issue of costs and does not authorize the Monitor to bear the costs of such proceedings. Thus, it would appear that the expense of the transcript should be borne by one of the parties in accordance with applicable cost and fee shifting provisions under federal law. See, e.g., Rule 54(d) of the Federal Rules of Civil Procedure and 42 U.S.C. § 1988. Inasmuch as such determinations are also outside the jurisdiction of the Monitor and within the purview of the Court, absent agreement, a motion should be made to the Court.

LIST OF APPENDICES

REQUIREMENTS FOR THE DEVELOPMENT AND IMPLEMENTATION OF INDIVIDUAL HABILITATION PLANS

(Welsch v. Levine, Court Monitor's Findings and Recommendations, Re: Hearthside Homes (January 1986))*

For a placement to appropriately meet the individual needs of class members, an IHP must be assured for each individual which has been developed by an appropriately constituted interdisciplinary team based upon the class members' assessed needs and strengths, and implemented in a comprehensive and integrated manner in and across residential and day programs and other appropriate, natural, functional, and/or community environments and settings. It must be monitored through collection of objective data and evaluated regularly to determine whether the program is effective, and should be continued, terminated or modified as necessary in light of that evaluation. The selection of goals, objectives and teaching or implementation strategies should be based on the integration of pertinent evaluations, input, and views of the interdisciplinary team members and any other relevant contributors as more fully described below.

1. An IHP must be based upon a comprehensive assessment of the class member's individual needs, strengths, deficits, interests, reinforcers, and capabilities through appropriate

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* These requirements have been extracted from the above-mentioned Findings, which also provide the rationale and explanation for each component. See in particular Part II(D) of the Findings.

standardized tests, formal and informal evaluations, interviews, and information gathering and analysis. The assessment must identify individual needs which, if remediated, compensated for or accommodated will assist the individual to function and participate more independently and fully in his/her present and future environments. To the extent expert or professional assistance is necessary to determine particular needs, expert or professional personnel must be involved in the assessment process.

2. Long-term and annual goals must be selected which, if achieved, will allow the class member to function and participate more independently and fully in his or her present and future environments. The annual goals, in particular, should be stated in measurable and behavioral terms. This goal selection process should be completed by an interdisciplinary team which includes:

(a) the class member,

(b) the class member's parent, guardian, or if possible, other family representative,

(c) the responsible county case manager,

(d) persons who interact with the class member regularly in the residential or day program, and,

(e) expert or professional personnel whose direct involvement in the team planning process may reasonably be said to be necessary in order that appropriate judgments may be made in the goal selection process.

3. Short-term objectives must be included in the IHP and designed to result in the achievement of the annual goals

developed for the class member. These objectives must be time-limited and be stated so that measurable behavioral criteria can be used to determine whether implementation of that program has resulted in achievement of the objective.

4. For each objective in a class member's IHP, there must be a written intervention plan describing specific individualized teaching steps and teaching strategies to be implemented in order to achieve that objective which includes a projected schedule of implementation and names staff persons responsible for that implementation. The method to be followed must be developed with consideration of the class member's needs, interests, preferences, and physical and mental limitations. It must utilize methods and places of instruction or implementation (including, as appropriate, natural or community settings) which will assist the individual in generalizing and maintaining skills once and as they are acquired. As necessary, teaching strategies should be implemented in and coordinated across environments, shifts, and programs.

5. The class member's progress or lack thereof toward meeting the objectives must be regularly reviewed, at least monthly or more frequently, as needed or as prescribed, so that timely and necessary modifications can be made. Program records (including objective data) must be recorded with sufficient frequency and kept in adequate detail to allow the class member's progress toward the objective to be evaluated.