July 9, 2002

The Honorable Thomas J. Vilsack
Governor of Iowa
State Capitol Building
Des Moines, IA 50319

Re: Investigation of Woodward State Resource Center and Glenwood State Resource Center

Dear Governor Vilsack:

On March 22, 1999, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, that we were investigating conditions at two state-operated facilities for the developmentally and mentally disabled: the Woodward State Hospital-School (subsequently renamed Woodward Resource Center) (Woodward) in Woodward, Iowa, and the Glenwood State Hospital-School (subsequently renamed Glenwood Resource Center) (Glenwood), in Glenwood, Iowa. In November 1999, and again in April and May 2001, we visited both facilities. At an exit interview conducted on the last day of each facility visit, we verbally conveyed our preliminary findings to counsel and senior Department of Human Services and facility officials. Consistent with the requirements of CRIPA, we are now writing to apprise you of our findings.

As a threshold matter, we wish to acknowledge, and express our appreciation for, the extensive cooperation and assistance provided to us by the administrators and staff of these two facilities. We hope to continue to work with the State of Iowa and officials at Woodward and Glenwood in the same cooperative manner in addressing the problems that we found. Further, we note that both facilities are staffed predominately by dedicated individuals who are genuinely concerned for the well-being of the persons in their care.

We conducted our investigation by reviewing medical and other records relating to the care and treatment of individuals at these two facilities; interviewing administrators, staff and residents; and conducting on-site surveys of the facilities. Our findings are supported by the assessments contained in our expert consultants' reports.

At the time of our 2001 visits, the Woodward census was approximately 280 residents and the Glenwood census was approximately 385 residents. At both facilities, residents' mental disabilities range from mild to profound. They possess diverse abilities and functional levels. Some residents are more reliant on staff to assist them in meeting their daily needs, while others are much more independent and capable of making decisions for themselves. There are a number of individuals at each facility who have developed maladaptive behaviors. Many of them have seizure disorders, ambulation issues or other health care needs. A significant portion of Glenwood's population is medically fragile. More than half of each facility's residents have been diagnosed as having one or more psychiatric disorders.

Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982). Similar protections are accorded by federal statute. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483 (Medicaid Program Provisions). The State also is obliged to provide services in the most integrated setting appropriate to individual residents' needs. Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130 (d); see Olmstead v. Zimring, 527 U.S. 581 (1999).

Both Woodward and Glenwood excel in various respects, many of which are discussed below. In particular, each facility has taken innovative, aggressive steps to become a resource for the surrounding community. Woodward's general medical care is good, on the whole, as is Glenwood's nutrition management program. In other areas, however, such as Woodward's use of restraints, Glenwood's general medical care and both facilities' psychiatric and psychological care and community placement programs, they do not provide constitutionally or statutorily mandated levels of care. Our findings, the facts supporting them, and the minimum remedial steps that we believe are necessary are set forth below.

I. RESTRAINTS AND RESTRICTIVE PROCEDURES

A. Woodward

From April 2000 through March 2001, an average of 56 Woodward residents each spent about 18 hours in mechanical and manual restraints each month, according to Woodward's "monthly restraint reports." Some individuals, such as RI and DM, were repeatedly restrained for more than 300 hours a month, as part of behavior management programs. A number of Woodward residents, such as EK, DS, PN, and ED, were regularly placed in four- and five-point restraints in excess of 10 hours a month. Also, residents such as HC, GG and JP occasionally have been immobilized in a so-called "papoose board," either during medical procedures or as part of a behavior program.

Separately, and over the same period, an unreported percentage of Woodward residents were placed in helmets, jumpsuits and mittens for approximately 870 hours each month, according to Woodward's "monthly behavioral intervention reports." The latter three devices, though classified as behavioral interventions, are also restraints; they were used in response to behavioral issues to restrain individuals from accessing parts of their bodies.

Totaling together the hours that are identified in the "monthly restraint reports" during the months from April 2000 to March 2001 and the separate tally for the same period of hours in restraints identified in the "behavioral intervention reports," about 56 Woodward residents each spent approximately 33 hours in restraints per month.

The use of restraints at Woodward places individuals at risk of harm. First, the prevalence of their use indicates that restraints are substituting for needed behavioral supports; individuals are physically or mechanically prevented from engaging in challenging behaviors instead of receiving effective treatment to address the cause of those behaviors. Although restrictive interventions may be appropriate in true emergency situations, their use as a long-term behavioral intervention is not appropriate. The generally accepted practice is that nonrestrictive interventions are an effective alternative when they are based on proper assessments and correctly designed and implemented. Further, restrictive interventions do not generally improve behaviors.

This point is illustrated by RI, who spent at least ten hours a day in restraints for virtually every day of the 12-month period reviewed. RI's records show that he is subjected to restraints because he engages in pica. His records show no evidence that potential medical or nutritional conditions that can lead to pica were ever considered, and his records indicate that behavioral causes of his condition have not been correctly assessed. His records show that, possibly as a consequence of these deficiencies, his behavior support plan has had no impact on his pica.

Seventy-eight Woodward residents have restraints or time out (the latter of which involves removing an individual from an environment and conditioning his/her freedom of movement on certain behaviors)

as part of their behavior support plan. This means that each of these individuals' behavior support plans permits the use of specific restrictive interventions if they engage in certain behaviors. Our investigation was unable to locate any evidence showing that the use of these restrictive interventions has produced clinically significant positive changes in the behavior of these individuals. In other words, they are not getting better for having been restrained, isolated or otherwise physically restricted. Certainly, long-term use of restrictive interventions on these seventy-eight individuals would constitute a significant departure from generally accepted standards of care.

Second, Woodward's extensive use of restraints means that individuals with diminished comprehension, some of whom have been sexually or physically abused and suffer from Post Traumatic Stress Disorder, are subjected to the significant psychological harm that comes from being physically held down or restrained.

Finally, Woodward's residents regularly are physically injured in restraints. Woodward incident reports from 1999 and 2001, the two years for which we have such data, identify numerous individuals suffering multiple abrasions, open wounds, floor burns, reddened areas and bruises while in restraints. Although the cause of injury is sometimes unclear, and the frequency of injury while in restraints appears to be decreasing, the reports indicate an on-going pattern of physical harm due to restraint use. This harm can be most severe. In March of 2001, D.D.[(1)], a forty-five-year-old Woodward resident, died after being placed in three-point restraints. The primary cause of death, according to the State Medical Examiner's autopsy report, was "compressional/positional asphyxia[] occurr[ing] during physical restraint by other individuals." Accordingly, D.D.'s death was classified as a homicide; no criminal charges have been brought.

Woodward direct care staff receive training on restraint use, as well as periodic de-escalation training. D.D.'s death, involving the incorrect use of restraints in the presence of five staff members, demonstrates that staff are inadequately trained, or possibly noncompliant with training.

Interviews by facility security personnel of each of the five staff members who witnessed or participated in restraining D.D. show that he was placed on a hard surface on his stomach, although he had a behavior plan that specified that his restraints were to be applied while he was "sitting down or lying face up," and risk of asphyxiation is usually heightened by placing an individual face down. Further, according to Woodward's investigation, staff immobilized D.D.'s head with pressure in a manner not authorized in his behavior plan nor otherwise authorized or taught at Woodward. Finally, staff did not continually observe and assess D.D.'s physical condition. When interviewed by facility security personnel, none of the five staff persons showed an appreciation for or awareness of these deficiencies.

Woodward's use of restrictive procedures, apart from restraints, is also problematic. For instance, as of April 2001, the facility maintained electronic tracking devices on at least three people to monitor their movements while at the facility. Electronic tracking for these three individuals had no therapeutic value. In fact, they are used as substitutes for therapeutic treatment. That is, they are used for the convenience of staff, not for the care of individuals. This is incompatible with the State's obligation to provide minimally adequate supports to ensure freedom from undue restraint. Youngberg, 457 U.S. at 324.

Since our 2001 tour, Woodward's administration has stated that the facility is taking extensive measures to reduce the use of restraints and restrictive procedures, along with the associated harms. These steps reportedly include retraining staff, revising restraint policies, and expanding use of alternative responses. The representations of remedial action are encouraging, but Woodward's problems in this area have been longstanding; actual results will provide the best measure of its progress.

B. Glenwood

Glenwood has achieved a substantial decline in the frequency of occurrences in which restraints and restrictive procedures are used, as measured from August 1999 to May 2001. However, these impressive results appear to be diminished by data from January 2000 to February 2001, indicating that the collective, total time that individuals spend in restraints and time out has remained fairly constant. Together, these data suggest that, while individuals are restrained less often, they spend more time in restraints, per occurrence, than before. Although Glenwood has made significant progress in this area, its work is not complete, as it appears that individuals are restrained for excessive periods of time.

II. PSYCHIATRIC AND BEHAVIORAL SERVICES

A. General Psychiatric Services

1. Psychiatric Assessments

Minimum standards of care dictate that the psychiatric diagnosis of each individual be justified in a generally accepted professional manner. At both Woodward and Glenwood, psychiatric assessments were not performed to substantiate current diagnoses in any formal or consistent manner. In general, the documentation reflects an inadequate psychiatric evaluation of Woodward's and Glenwood's residents. This is a serious concern, given that both facilities have diagnosed well over one-half of their residents as having psychiatric disorders.

To take an example, one of AB's diagnoses is Borderline Personality Disorder. Her chart does not identify which markers of this disorder she exhibits. Nor does it otherwise set forth the basis upon which this disorder, which requires significant cognitive ability to manifest itself, could be present in an individual with profound mental retardation and very limited expressive skills.

2. Psychiatric Diagnoses

The average facility for individuals with mental retardation has a prevalence of psychiatric disorders well below 50 percent. By comparison, Woodward has diagnosed approximately 85 percent, and Glenwood approximately 60 percent, of their respective populations as having psychiatric disorders. It would be noteworthy if the epidemiology of Woodward's and Glenwood's residents varied so significantly from the average facility. In fact, however, many of these diagnoses are dated, unsubstantiated or incorrect. For example, at Woodward, RDW was diagnosed with Conduct Disorder, notwithstanding that RDW is 55-years-old and Conduct Disorder is not found in adults, with or without a mental disability. Numerous Woodward and Glenwood residents were diagnosed with Intermittent Explosive Disorder when their psychological reports specify other causes of their problem behaviors.

3. Psychotropic Medications

Approximately 68 percent of Woodward's population and 60 percent of Glenwood's population were receiving psychotropic drugs. Often, the justification for continued use of psychotropic medication was staff recommendations, not empirically supported decisions justifying a need for the medication. At both facilities, the unjustified use of multiple psychotropics to address the same condition was common, as was the practice of administering psychotropics to treat undiagnosed conditions. Further, psychotropics regularly were administered without an indication as to what symptoms are targeted or whether the medication is successful. Finally, the facilities have individuals who have received psychotropics for years without any clinically significant improvement.

There are strong indications that psychotropics are prescribed at both facilities to address staff complaints about individuals with challenging behaviors, that is, prescribed for the convenience of staff. Physicians at Glenwood have openly expressed concern about being pressured in this regard.

Polypharmacy (that is, the use of multiple drugs to treat the same indication), while possibly appropriate in some circumstances, always should be justified. None of the reviewed Woodward and Glenwood charts reflecting polypharmacy provided any written justification as to why multiple medications were used to target the same condition. Certainly, no basis was provided showing how multiple psychotropic medications work synergistically or separately to address the same problem.

Some individuals, such as Woodward's CD, have developed medication-related seizures and, nevertheless, have been placed on other medications that facilitate the onset of seizures. Some Woodward residents, such as RI and DAP, have received powerful psychotropic medications that have not demonstrably improved their psychiatric or behavioral problems but have caused them to develop seizures and other permanent physical side effects.

With regard to seizures and other serious permanent side effects of psychotropic drug use, the 90-Day Psychotropic Medication Review and the side effect assessments at Woodward and Glenwood have not provided residents with adequate protection, as the above examples confirm. For data derived from side effect assessment tools to be meaningful, they must be read in connection with other clinical data, including but not limited to, the state of the disorder, the psychotropic dosage levels and durations of use, and available treatment alternatives. The charts do not evidence that such factors are uniformly considered when assessing side effects.

Chart review also indicates multiple instances in which drugs are administered for conditions for which no identified diagnosis has been made. At Woodward, CD receives Luvox each day for signs and symptoms of depression, including difficulty sleeping. Although CD's chart states "diagnosis is reviewed and appears appropriate at this time," nowhere does the diagnosis include the depression for which she receives daily medication. AB also receives Luvox for probable depression but does not have a diagnosis of depression. DJ receives Paxil to address depression and pain but does not have a diagnosis of depression; nor does the chart provide an explanation of the pain that is being medicated.

There are also repeated instances in which drugs are administered without any indication of what condition is targeted or whether the drug in question is providing effective treatment. For instance, at Woodward, RP is on Trilafon, but his chart does not indicate why, what results are expected, or whether this medication is providing effective treatment. At Glenwood, there is no indication in BOT's pharmacological and behavioral program what, in particular, the psychotropic medications that he/she receives are addressing and what effects these drugs are having.

The foregoing examples raise grave concerns regarding the use of psychotropics at both facilities, although it should be noted that the Woodward charts reviewed in 2001 also reflect an effort to decrease and discontinue the use of unnecessary psychotropic medication. These reductions appear to be well-considered, and are done with care, taking into account the effects on the individual and the views of staff. Nevertheless, a great amount of work is required in this area, as the health and well-being of many residents are endangered.

4. Treatment Outcomes Monitoring

At both facilities, residents with psychiatric disorder diagnoses frequently are poorly monitored for treatment outcomes. In this regard, there are numerous instances in which psychotropic medications are

not reassessed after having been administered for several years with a lack of significant behavioral change. The facilities' ability to monitor treatment outcomes is further compromised by the instances, noted above, in which psychotropic drugs are prescribed without a corresponding diagnosis and/or without identifying the targeted markers of the underlying psychopathology that is being treated. Glenwood's lack of institution-wide audits, reviews or summary reports regarding psychotropic medication use is another factor diminishing its ability to monitor treatment outcomes.

5. Pharmacy and Therapeutics Oversight

Typically, the Pharmacy and Therapeutics ("P&T") Committee provides leadership on drug prescriptions at a facility, examines the rationale for the use of polypharmacy, checks on medication errors, provides information on advances in medication, and evaluates data on side effects of medication, especially movement disorders. Woodward's P&T Committee is not performing these necessary functions. It does not assess general patterns and prevalence of psychotropic drug prescriptions. Glenwood does not even have a P&T Committee or another entity performing these functions. This constitutes a major gap in minimally adequate care services.

6. Informed Consent

In numerous instances when, presumably, the parent or legal guardian is not available or has not responded to requests for authorization, both facilities' superintendents have authorized the use of restraints and psychotropic medications for individuals, without having been appointed guardian. Federal regulation of facilities such as Woodward and Glenwood requires that there be written informed consent of the individual, parents (if the individual is a minor) or legal guardian. 42 C.F.R. § 483.440 (f)(3)(ii). The lack of informed consent regarding the use of psychotropic medications also runs afoul of the Due Process Clause of the Fourteenth Amendment. See Washington v. Harper, 494 U.S. 210, 221 (1990).

B. Psychological Services

Considerable, well-intended, efforts are made at both facilities to collect psychological data. Nevertheless, the behavioral data used in forming assessments is often inaccurate or incomplete in important respects. To some extent, this results from burdening direct care staff with excessive, unfocused, behavioral data recording requirements. In any event, as a psychologist noted in the case of Woodward's CD, the behavioral data at both facilities are often unreliable.

Further, assessments and findings regarding the function of behaviors are regularly overstated, inadequately substantiated or incomplete. As a result, they, too, are frequently unreliable. For instance, BK's chart, at Woodward, does not identify the signs and symptoms supporting the findings of obsessive compulsive disorder and pervasive developmental disorder. Without substantiation, the results of the functional assessment of Woodward's CD were interpreted to show that self injury occurred most often when CD could not escape noise, notwithstanding data showing that her highest rate of self injury occurred when she was alone.

Without explanation, in the case of Woodward's RI, certain results from a Functional Analysis Screening Tool ("FAST") were discounted as being "an artifact of the assessment instrument," while other results from the same instrument were fully credited. At Glenwood, each reviewed Behavior Development Plan contains the identical statement that "possible medical, psychiatric or other motivations" were considered and ruled out, but none of these plans points to data supporting this assessment. The relevant records indicate that psychologists at both facilities are prone to accept the

findings from FAST ratings selectively, apparently to justify assessments.

Compounding the questionable utility of the facilities' psychological assessments is the use of stale data. BLT's treatment program, at Woodward, was written based on an assessment made sixteen months earlier. If underlying aspects of BLT's behavior had changed in the interim, the treatment plan's therapeutic value would be questionable. LJ's current treatment plan, again at WRC, is based on FAST data now two years old. Her problem behaviors have continued at a high level, suggesting that reliance upon such old data is not appropriate.

As for psychological treatments, both facilities are heavily invested in the development of elaborate behavior support plans. These plans, however, frequently do not appear to be appropriate. For instance, if an individual, such as Woodward's CD, is injuring herself as a means of receiving stimulation and attention, as the behavioral hypothesis for her suggests, then placing her in restraints is unlikely to be an effective treatment, because restraining her does not teach her alternative, socially appropriate ways of behaving. Further, the psychiatrist's report suggests that her behaviors may have more to do with psychiatric illness than a failure to learn appropriate behaviors.

Similar examples were found at Glenwood. BOT's behavior development plan contains the unsubstantiated statement found in other charts that "possible medical, psychiatric or other motivations for the target behavior have been considered." It also claims to have taken into account BOT's pharmacological treatment, although why he is receiving drugs, what they are specifically targeting and what effect they are actually having on him were not considered or, at least, not in a manner permitting meaningful review.

Moreover, the complexity of BOT's plan, involving seven different interventions, jeopardizes its feasibility. This problem is typical of many of the behavior support plans at both facilities. While perhaps appropriate for the study of a discrete behavior in a laboratory setting, they require an unrealistic level of sophistication and time commitment from direct care staff. More fundamentally, they are not, as a general matter, measurably improving the lives of Woodward and Glenwood residents. In other words, they often provide ineffective treatment.

C. Integration of Pharmacological and Behavioral Plans

Combined assessment and case formulation should occur to develop an integrated behavioral and psychopharmacological treatment and, at a minimum, ensure that related treatments do not conflict. To a large extent, however, this does not take place at either facility. The psychiatric care and behavioral care of Woodward's and Glenwood's residents are largely uncoordinated, to the point that practitioners of each discipline develop assessments, diagnoses and treatments without integrating or even considering those of the other discipline. In the context of these facilities, this failure makes many important treatment decisions essentially arbitrary.

Woodward's BLT receives psychotropic medication daily to treat depression, but nothing in her chart indicates that this fact was considered to be important in the preparation of her behavior support plan. The behavior support plan of Woodward's CD notes that she has seizures approximately bi-monthly, but this fact is not mentioned in the psychiatric consultation, not even in reference to her daily medication with Seroquel, a drug that lowers seizure thresholds. JP and BOT of Glenwood present similar problems, outlined above.

Many of these cases were provided by Woodward and Glenwood as examples of the integration of pharmacological and behavioral treatments, but they do not indicate an appreciation of what such

integration entails. Further, there is a significant lack of proper case formulation, even apart from considerations of psychopharmacological treatment. In fact, there is a lack of integration at the diagnostic level, as when a psychiatrist diagnoses an individual with a psychiatric disorder such as Intermittent Explosive Disorder and a psychologist irreconcilably finds that behavioral motivations account for the same disorder.

In this regard, approximately 83 percent of all individuals at Woodward who have a complete behavior support plan are also on psychotropic medication for essentially the same target behaviors. The percentages appear to be similar at Glenwood. It further appears that the psychologists writing these behavior development plans give little consideration to any significant contribution that psychiatric disorders may make to the targeted behaviors. In effect, each facility's psychologists and psychiatrists independently provide treatment for the same behaviors. These independent treatments, as implemented, largely have not been effective; most of the individuals subjected to them are burdened with behavioral problems or psychiatric disorders that are unimproved. The failure of the facilities' psychiatrists and psychologists to collaborate effectively has contributed to these results.

III. GENERAL MEDICAL CARE

A. Woodward

The information that we have seen indicates that, exclusive of the psychiatric issues addressed above, Woodward is providing good general medical care to its residents.

Three full-time physicians provide medical services at Woodward, one of whom serves as medical director. Two of these three physicians have been at Woodward for more than twenty years. The third arrived in 1993. With supplemental support from an outside physician, Woodward doctors provide twenty-four-hour on-site coverage. In short, Woodward residents have the benefit of immediately available physician services, provided by doctors who, for the most part, are well-acquainted with the individuals whom they are treating.

Woodward medical services are also well-supported by specialists at McFarland clinic, in Ames, Iowa. McFarland physicians see Woodward residents on a same-day basis, if necessary. They also travel to the facility to conduct at least seven separate clinics, each of which occurs once or twice a month, except for the quarterly dermatology and ophthalmology clinics.

Although the facility should consider expanding its preventive care guidelines to address issues particular to its aging population, such as bone marrow screening, the guidelines currently in place are comprehensive. They include screening for vision, hearing and dental care, physical side effects screening for individuals on psychotropic medications, cervical spine radiographs for individuals having Downs Syndrome, immunization schedules, mammogram protocols, and bone mineral density testing on post menopausal women.

B. Glenwood

About 40 percent of Glenwood's 386 residents are medically fragile; that is, in addition to having mental retardation, these individuals are nonambulatory, require a gastric feeding tube, have uncontrolled seizures or have severe osteoporosis. Seven Glenwood residents died between January 2000 and January 2001. Six of these deaths involved individuals under 50.

At the time of our latest visit Glenwood residents received general medical services from four full-

time physicians, with another due to start shortly thereafter. Glenwood's physicians appear to be competent and dedicated. Nevertheless, especially in light of the number of medically fragile residents, Glenwood's general medical services are not properly equipped to provide necessary care.

Facilities that regularly provide general medical services to a population such as Glenwood's, with significant numbers of medically fragile residents, typically have a medical director, or an equivalent position, who reports directly to the superintendent and is responsible for maintaining a consistent level of adequate medical care throughout the facility. Although Woodward's population is less medically needy, it has a medical director. Glenwood does not. In fact, Glenwood's administration repeatedly has involved itself in medical care decisions that are properly the responsibility of the facility's physicians, a troubling activity that would not likely occur if a competent medical director were in place.

Further, although it is standard professional practice to maintain a formal peer review system as a quality assurance tool and a means to ensure the provision of consistent medical care, Glenwood has no such system.

It is also standard practice in facilities like Glenwood to have a medical quality assurance program that monitors the quality of services the facility delivers and makes recommendations for improvement. Glenwood has no such program. Further, as noted above, it is also the norm to have a Pharmacy and Therapeutics ("P&T") Committee that, among other responsibilities, provides leadership on drug prescriptions at a facility, examines the rationale for the use of polypharmacy, checks on medication errors, and provides information on drug development. At Glenwood, there is no such committee.

Finally, although it is standard practice in facilities such as Glenwood to establish medical care policies and protocols to ensure the consistent provision of adequate medical care, Glenwood has none. Although, in some instances, it uses standing orders, these do not define the problem to be treated, guide in assessing a patient, set forth necessary steps if the condition does not improve with medication or treatment given, or identify trigger points for physician notification and intervention.

The absence of the foregoing components of adequate medical oversight has jeopardized the medical care of Glenwood's residents. In the case of at least one individual, JW, it has contributed to morbidity and mortality. Without appropriate medical protocols, Glenwood nurses lacked clear guidance when to notify physicians regarding JW's condition. The delays in assessing, diagnosing and treating his pneumonia contributed to the onset of sepsis and his death. The absence of a peer review system and a medical quality assurance program prevented Glenwood from identifying the delays after the fact and correcting the underlying problems, so that they could be avoided in the future.

IV. NEUROLOGIC CARE

A. Woodward

Neurology services are provided by two epileptologists from the McFarland clinic. Every Woodward resident having a seizure disorder diagnosis is evaluated. Each such resident is reevaluated on an annual basis regardless of seizure frequency, thereby preventing an asymptotic individual from remaining unnecessarily on an anticonvulsant for a prolonged period of time. Currently, no Woodward resident with epilepsy is receiving older barbiturates such as Phenobarbital or Mysoline. The facility is clearly attempting to eliminate consumption of unnecessary anticonvulsant medications. However, as discussed at § II.A.3 above, certain Woodward residents' seizure problems have been worsened by psychotropic medications, and greater coordination between neurologic and psychiatric care services is warranted.

B. Glenwood

As a general matter, erroneous diagnoses of epilepsy in mentally handicapped persons are common because of difficulties inherent in assessing their neurological conditions. In light of this problem, good medical practice necessitates that each individual who is admitted with a neurological diagnosis to a facility such as Glenwood be thoroughly evaluated by a neurologist at admission. Thereafter, individuals with a confirmed neurologic disorder who are receiving anticonvulsant medications should be regularly monitored by a neurologist for appropriateness of treatment and medication.

Glenwood has a well-qualified neurologist on staff. However, he has an extensive non-neurology caseload. Apparently, his other duties, at least in the past, have prevented him from examining at admission each individual arriving at the facility with a neurological disorder diagnosis. Also, he does not regularly monitor individuals on anticonvulsants to ensure that their treatment is effective and their medication appropriate. Further, notwithstanding that about 40 percent of Glenwood's residents receive anticonvulsant medications, the facility has not established a formal neurology clinic, nor developed standard treatment objectives or anticonvulsant prescribing practices. Consequently, the likelihood is substantial that many Glenwood residents are receiving ineffective neurological treatment or are unnecessarily exposed to potentially harmful drugs.

V. NUTRITION MANAGEMENT

Each facility has created a nutrition management team composed of speech and language pathologists, occupational therapists, nurses, dieticians and physical therapists or physical therapist aides. Glenwood's team also includes physicians and a dentist. At Woodward, physicians participate only on an as-needed basis.

The facilities have used the services of a consultant who is well-credentialed in assessing and treating individuals with dysphagia. The consultant has provided instruction to therapists and has conducted evaluation clinics.

At both facilities, instructions regarding the dining or feeding of specific individuals, including photographs of proper placements, are kept at the dining table.

A. Woodward

At Woodward, direct care staff receive four hours of training regarding problems associated with dysphagia but no other mandatory formal training in mealtime procedures. Much of the other nutrition-related training that is provided is not competency based, and some staff assist with meals without having received individual-specific training. Additional staff training is apparently contemplated but is not yet in place.

Woodward has also not implemented a screening program for individuals having nutrition management needs. Nor has it fully evaluated each resident identified as high risk in nutrition and provided appropriate mealtime plans for them.

B. Glenwood

Glenwood's speech and language therapists provide competency based training to direct care staff. Glenwood has developed standard operating procedures regarding food temperature and consistency, a list of preferred feeders, oral motor treatment protocols, and off-campus dining protocols. The protocols

and procedures are kept in a manual that is readily available in each house.

Glenwood's nutrition management team meets weekly and operates a continuous quality improvement plan in conjunction with food services. Further, charts are reviewed randomly and data on dysphagia and respiratory incidents are reviewed and evaluated to ensure continuous quality improvement.

Glenwood's team is proactive in providing care. Every Glenwood resident is screened at least once to determine his or her risk level. Individuals are regularly assessed, according to risk, during mealtimes.

The level and quality of Glenwood's training, interdisciplinary participation, data tracking and assessment, treatment, monitoring, and quality assurance in the area of nutrition management are commendable.

VI. PHYSICAL AND OCCUPATIONAL THERAPY

A. Woodward

Woodward residents are not receiving adequate physical therapy to meet their needs. The reviewed charts showed insufficient physical therapy involvement and scant physical therapy care planning. Although Woodward has a physical therapy aide and a part-time physical therapist on contract, it had, at the time of our latest visit, no physical therapist on staff. This raises concerns regarding the adequacy of staffing and of supervision for Woodward's physical therapy aide.

For occupational therapy, by contrast, Woodward has enlisted the aid of rehabilitation technicians from the University of Iowa to assist in developing effective positioning and repositioning of its nonambulatory residents. These technicians have also used state-of-the-art computer mapping of nonambulatory individuals to identify potential pressure sore areas and permit timely, preventative care of these areas. At the time of our tour, there had been no recent pressure-sore related hospitalizations from Woodward.

Wheelchairs and assistive devices at Woodward, as a general matter, were well-maintained and properly fitted for the individual using them.

B. Glenwood

Glenwood's physical and occupational therapy programs are good. In particular, Glenwood has the capability to fashion and extensively modify supports and assistive devices. These devices are well-maintained and assessed regularly to ensure proper fit with the individual using them.

Separately, Glenwood provides excellent hydrotherapy services to its residents. Its hydrotherapy facility is an impressive asset. It enables many nonambulatory individuals to walk with assistance in water or otherwise manipulate and relax stiffened body parts. It is also a significant resource for behavioral treatment.

VII. PROTECTION FROM HARM

A. Woodward

Over an extended period of time, Woodward has made steady progress in reducing the number of

incidents of injury occurring each month. Further, the proportion of all injuries requiring treatment by a physician has also decreased, especially in 2000 and 2001. Woodward's use of restraints has artificially contributed to this decline, in that restraints suppress the behavior without correcting it. Nevertheless, the long-term downward trend in incidents shows that, as a general matter, the facility has achieved significant improvement in this area. That more work remains to be done is evident in the death of D.D. while in restraints, as discussed above at § I.A.

B. Glenwood

Glenwood's monthly incident reports show that certain types of harmful incidents, such as those requiring emergency room admission, appear with sufficient frequency and regularity to warrant analysis of their root cause. A review of relevant records and interviews at the facility surfaced nothing to indicate that such an analysis had been undertaken. Further, there do not appear to be any systematic analyses in terms of other variables that may predict when, where and in whose presence these incidents occur, so that steps could be taken to reduce or prevent them.

Similarly, the Risk Management Committee regularly identifies instances where review of certain restraint use is warranted, but there is little to indicate that a review is, in fact, undertaken with its conclusions reported to the committee. For instance, the February 28, 2001 committee minutes read, "Discussed [SJ] use of helmet for six times or 150 minutes. Kim and Dick will follow up on the emergency restraint." However, the minutes of successive meetings make no mention of this issue.

The issue of adequate quality assurance and prevention from harm arises in still other contexts. At a minimum, as noted above, Glenwood lacks a Pharmacy and Therapeutics ("P&T") Committee and a medical peer-review committee, or the equivalents, to ensure that problematic trends in treatment and care of individuals are detected and addressed, and it does not track facility-wide psychotropic medication use. Glenwood also had no method, as of the time of our visit, to track errors in the administration of medications and identify corrective actions. Finally, following our tour, we received credible allegations that two Glenwood staff have sexually abused residents. A facility investigation as to one staff person was inconclusive, but noted that, on prior occasions, he had been found with facility residents in questionable circumstances. Criminal charges are pending against the other staff member. These allegations raise issues regarding, among other things, the adequacy of staff supervision. In summary, Glenwood lacks important and necessary safeguards to adequately protect its residents from harm.

VIII. HABILITATION

Both facilities have taken steps to improve the habilitation and training (also known as active treatment) provided to their residents. While significant, their efforts are incomplete, and the available data suggest that, certainly as to Woodward and probably as to Glenwood, residents are not receiving appropriate habilitation.

Woodward and Glenwood follow, to an extent, an Essential Lifestyle Planning ("ELP") model, which is typically used to identify and address habilitation objectives, as well as reasonable supports, that will help the individual attain an appropriate lifestyle of his or her choosing. Both facilities have done well in using the ELP model to determine individuals' likes, dislikes, preferences, and strengths. However, neither facility has succeeded in assimilating this information into planning the individual's habilitation.

For example, according to his Woodward ELP, BJ's favorite activities involve models, cars, tools and music, but Woodward's habilitation objectives for this resident focus almost exclusively on perceived

deficiencies, such as "Will not engage in disruptive behavior; Will not engage in thinking errors, and Will tell time." To a great extent, the facilities ignore individuals' life interests and goals when planning their habilitation and focus instead on the facilities' objectives, which tend toward adapting the individual to life in an institution.

Furthermore, whatever the habilitation objectives may be, the available data indicate that Woodward largely has been unable to achieve them, and nothing that we have seen indicates that Glenwood has fared better. Woodward data show that there is limited meaningful engagement in habilitation. In the vast majority of cases, the habilitation failed to produce "on-task" behavior (that is, the behavior which the habilitation is intended to manifest) during the six-month period commencing September 2000. Similarly, a sample of learning-based programs showed that, in August 2000, no progress was made in the majority of them.

IX. SERVING INSTITUTIONALIZED PERSONS IN THE MOST INTEGRATED SETTINGS APPROPRIATE TO THEIR NEEDS

Facility records indicate that, over a 15-month period ending in March 2001, Woodward had outplaced only 18 residents, 2 of whom were transferred to Glenwood, and had identified an additional 2 as suitable for placement. Similarly, for the same period, Glenwood had outplaced only 19 residents, although it had identified an additional 32 residents as suitable for placement. Individual staff members have made considerable effort to facilitate appropriate community placement opportunities, but the facilities, themselves, have not implemented adequate steps regarding assessments of individuals, consultations with guardians and family members, identification of appropriate supports and settings, and planning of the transition process. Consequently, individuals who desire to live in the community and who reasonably can be accommodated there are denied an adequate opportunity to do so. This is not in accordance with the State's obligations under Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 et seq., and the regulations promulgated thereunder, 28 C.F.R. § 35.130 (d).

As a threshold matter, neither facility has established protocols ensuring that individuals are adequately assessed to determine the most integrated setting appropriate for their wants and needs. Consequently, treatment professionals' assessments of individuals have been haphazard or altogether absent. Although both facilities make effective use of the Essential Lifestyle Planning ("ELP") model to determine individuals' wants and preferences, neither has implemented the ELP model, or any other approach, to consistently and timely identify the most reasonably suitable environment for the individual, the individual's preferences in that regard, and the accompanying supports for living there.

Second, as discussed above, both facilities have failed to translate individuals' goals, wants and needs into adequate habilitation. More particularly, with a few significant exceptions, the focus of habilitation has been on behavioral issues.

Third, although family members and guardians, of course, will play prominent roles in decisions about living arrangements, the facilities have halted consideration of community placement for certain individuals, based on perceived objections of persons other than the individual, herself. At the same time, the facilities have failed regularly to inform family and guardians about available supports that have helped individuals with significant disabilities succeed in the community. A decision to stay in or leave an institution is not meaningful if it is not informed.

Finally, though Glenwood is making significant progress in this area, the timeliness, consistency and completeness of transition and community placement planning are problematic at both facilities. Current planning in these areas is informal. At Woodward, it often occurs either shortly before formal discharge

or, in some cases, following an individual's move. Glenwood has engaged in several months of appropriate planning for some individuals, such as SJ, JS and EF. Other Glenwood plans, for JC and LK, for instance, appear to be incomplete and somewhat hurried. Not surprisingly, the latter two individuals returned to Glenwood. At both Glenwood and Woodward, the lack of a formalized transition and community placement planning process at the organizational and individual levels needlessly subjects the success of community placements to chance.

Separately, Glenwood had, as of March 2001, 27 residents under the age of 18. Ten of them were 12 or younger. Record review indicates that many of these children came to Glenwood because of a lack of available in-home supports. As discussed below, Glenwood has aggressively expanded its capability to provide community support services. It should consider linking this expanded capability with a targeted effort to assist in returning to the community those children in its care who can do so with reasonable support.

X. COMMUNITY SUPPORT SERVICES

Both facilities are making efforts to serve as community resources and have developed an array of community support services, including campus and in-home respite care, thirty-day assessment services and other diagnostic and evaluation services, in-home supported living and family services, consultations for family and community providers, and waiver-funded group homes. Glenwood has made particular efforts in this regard, locating a community school and a residence for the elderly on its grounds. Some of the elderly residents have become involved in foster grandparent and senior companion programs, which are excellent examples of creative and effective community outreach.

In general, all of these services have helped to somewhat integrate the facilities themselves into the community. They also have enabled some individuals to continue living in the community. The facilities' efforts in this regard are commendable.

XI. RECORD KEEPING

Maintaining accurate, complete and workable records for every institutionalized person is difficult but fundamentally important. Record management at both facilities is strikingly poor. Consequently, individuals are needlessly exposed to risk of harm.

A. Woodward

From the first page of documentation, there were errors of fact in every one of the numerous patient charts and client records that one of our consultants reviewed. The charts were full of documentation errors, specific documents were hard to find, information was missing, and even Woodward's staff had difficulty helping him locate information and documentation. Meaningful record quality assurance is nonexistent, and the numerous deficiencies suggest a lack of concern for detail.

B. Glenwood

Here, too, the records were full of errors, and specific consult records and notes were very difficult to locate. Further, there is frequently a significant lag time between when a note is dictated or written and when it is placed in the chart. Much of the writing in progress notes in the charts is illegible, and the notes are not consistently dated, timed and signed. Again, these problems indicate poor to nonexistent quality assurance and oversight and a lack of care of detail.

XII. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of Woodward and Glenwood residents, Iowa promptly should implement the minimum remedial measures set forth below. These apply to both facilities unless otherwise indicated.

A. Restraints and Restrictive Controls

Any device or procedure that restricts, limits or directs a person's freedom of movement (including, but not limited to, mechanical restraints, physical/manual restraints or time out procedures) ("Restrictive Controls") should be permissible only as a last resort. More specifically, the facilities should:

1. Eliminate use of mechanical restraints from all behavior plans and programs and limit use of mechanical restraints to true emergency situations.

2. Eliminate prone holds in all circumstances.

3. Eliminate use of all other Restrictive Controls except:

(a) when active treatment strategies have been considered and attempted and would not protect the person or others from harm, or prevent property damage;
(b) other less intrusive or restricted methods have been ineffective; and
(c) as a planned intervention in approved behavior support plans, or on an emergency basis, when an unexpected crisis situation occurs in which a person's behavior poses an immediate risk of harm to self or others.

4. Provide all direct care staff with competency based training on emergency restraint use.

5. Develop and implement a policy on restraints and restrictive measures that comports with current professional standards.

6. Convene an interdisciplinary team to review and revise, as appropriate, the behavior support plan of any individual placed in mechanical restraints more than three times in a one-month period.

B. Psychiatric Services

No resident should receive psychotropic medications without having first been thoroughly evaluated and diagnosed according to current professional standards of care, including with sufficient documentation to withstand clinical scrutiny. More particularly, the facilities should:

1. Develop standard psychological and psychiatric assessment and interview protocols for reliably reaching a psychiatric diagnosis for individuals with mild and moderate mental retardation and standard protocols for individuals with severe and profound mental retardation. Use these protocols to assess each person upon admission for possible psychiatric disorder(s).

2. Undertake a thorough psychiatric evaluation/workup of all individuals currently residing at each facility, provide a clinically justifiable current diagnosis for each individual, and remove all diagnoses which cannot be clinically justified.

3. As to all residents residing at the facilities receiving psychotropic medications, undertake a new psychiatric consult to ensure that all such medications are appropriate and are specifically matched to current, clinically justifiable diagnoses.

4. Ensure that each psychotropic medication is prescribed in its optimal therapeutic range.

5. If more than one drug is prescribed for the same indication, provide a particularized justification at the mechanism level for the polypharmacy, and eliminate all polypharmacy that cannot be justified at the mechanism level.

6. In all prescriptions and psychiatric consults, specify the marker or target variables for each drug and the expected time line for the effects to be evident. Monitor the use of each such medication against the markers or target variables that have been identified to evaluate its effect. Reassess diagnoses and treatments as appropriate.

7. Ensure that, where psychotropic medications are used, ongoing consideration is given to the potential impact of the individual's other medications, and the impact on other aspects of the individual's health.

8. Ensure that psychiatry hours at each facility are sufficient to enable the psychiatrists to provide adequate services.

9. Fully integrate pharmacological treatments with behavioral and other interventions.

10. Obtain informed consent or proper legal authorization prior to administering psychotropic medications and other invasive treatments.

C. Psychological Services

Behavioral data used in forming psychological assessments should be current, accurate and complete; behavioral assessments should be complete and substantiated; treatments should be geared toward improving the individual's quality of life, and all of the foregoing should be implemented according to current professional standards of care, including with documentation sufficient to withstand clinical scrutiny. More particularly, the facilities should:

1. Develop standard protocols for efficient, accurate collection of behavioral data, including relevant contextual information.

2. Develop standard psychological assessment and interview protocols. Ensure in these protocols that possible medical, psychiatric or other motivations for target behaviors are considered.

3. Use these protocols to ensure that functional assessments and findings about behaviors are adequately substantiated, current and complete. In this regard, ensure that other potential functions have been assessed and excluded.

4. Ensure that behavioral plans are written at a level that can be understood and implemented by direct care staff.

5. Ensure that outcomes of behavioral plans include fundamental objectives, such as

reduction in use of medication, enhanced learning opportunities, and greater community integration.

6. Ensure that outcomes are frequently monitored, and that assessments and treatments are reevaluated promptly if target behaviors do not improve.

7. Ensure that the psychologist:individual ratio is adequate to support both individuals needing behavior programs and the facility's general population.

D. Integration of Pharmacological and Behavior Plans

Combined assessment and case formulation should occur to develop and implement an integrated behavioral and psychopharmacological treatment and, at a minimum, ensure that related treatments do not conflict. More particularly, the facilities should ensure that:

1. Psychiatric disorders or conditions that require primary, or adjunctive psychopharmacological treatment, are distinguished from essentially learning-based behavior problems that require behavioral or other interventions. Expressly identify those that have overlap. Provide appropriate, integrated treatment.

2. Behavior development plans reflect an assessment, in a manner that will permit clinical review, of medical condition(s), psychiatric treatment and the use and impact of psychotropic drugs.

E. General Medical Care

Individuals with health problems should be promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed and treated, consistent with current professional standards of care, including with documentation adequate to withstand clinical scrutiny. More specifically, Glenwood should:

1. Retain a well-qualified medical director who would be responsible for maintaining a consistent level of adequate medical care throughout the facility.

2. Establish a formal medical peer-review system.

3. Establish a medical quality assurance program that:

(a) actively collects data relating to the quality of medical services;
(b) assesses these data for trends;
(c) initiates inquiries regarding problematic trends and possible deficiencies;
(d) identifies corrective action; and
(e) monitors to ensure that appropriate remedies are achieved.

4. Establish a system to track errors in the administration of medicine.

5. Establish uniform medical care policies and protocols to ensure the consistent provision of medical care.

6. Monitor and analyze facility-wide psychotropic medication use so that policies,

procedures and drug prescribing practices can be based on reliable quantitative data.

F. Neurologic Care At Glenwood

Individuals with a neurologic disorder diagnosis should be treated and regularly monitored by a neurologist, according to current professional standards of care, including with documentation adequate to withstand clinical scrutiny, to ensure that the treatment and medication are appropriate. More particularly, Glenwood should:

1. Ensure that each individual who is admitted with a neurological diagnosis is thoroughly evaluated by a neurologist at admission.

2. Develop and implement standard seizure treatment objectives and anticonvulsant medication prescription practices.

3. Ensure that a well-qualified neurologist thoroughly evaluates every resident having a seizure disorder diagnosis and reviews all people with seizure disorders to ascertain a goodness-of-fit among assessment, diagnosis and treatment.

4. Implement a facility-wide, monthly side-effects monitoring system specifically for anticonvulsant medications.

5. Minimize use of older anticonvulsant medications, such as barbiturates and hydantoins, in favor of newer ones having fewer cognitive, behavioral and physical side effects.

G. Nutrition Management At Woodward

All facility residents should be assessed for swallowing difficulties. Residents having swallowing difficulties should be supported with appropriate nutritional supports. More particularly, the facilities should:

1. Conduct facility-wide screening for all residents not already identified as having nutrition management needs.

2. Fully evaluate each individual identified as nutritionally high-risk and develop and implement mealtime plans for each such individual.

3. Ensure that residents identified as nutritionally high-risk are regularly re-assessed.

4. Develop and implement formal, competency-based staff training on mealtime procedures, supplemented with quality assurance monitoring of mealtimes.

5. Ensure that only staff who have demonstrated competency with an individual's mealtime plan provide assistance to that individual.

H. Physical Therapy at Woodward

In accordance with current professional standards of care, each individual having physical disabilities, including but not limited to those in wheelchairs or experiencing walking difficulties, should be assessed regularly, and should be assessed promptly after a significant change in physical status, to

identify and address physical therapy needs and the adequacy of supports. The assessment should be documented in a manner adequate to support clinical review. More particularly, Woodward should:

1. Provide physical therapy and physical therapy planning for each resident in need of physical therapy interventions.

2. Ensure that therapeutic positioning is adequate to support physical needs and is reviewed regularly to ensure proper implementation.

3. Ensure that staff involved in therapeutic positioning receive competency-based training on therapeutic positioning, particularly in addressing scoliosis, mealtime needs, and functional seating.

I. Protection from Harm

Incidents involving injury and unusual incidents should be reliably and accurately reported and investigated, with appropriate follow-up. More particularly, the facilities should:

1. Ensure that incidents involving injury and unusual incidents are tracked and analyzed to identify root causes.

2. Ensure that analyses are transmitted to the relevant disciplines and direct-care areas for responsive action, and responses are monitored to ensure that appropriate steps are taken.

3. Ensure that assessments are conducted to determine whether root causes have been addressed and, if not, ensure that appropriate feedback is provided to the responsible disciplines and direct-care areas.

J. Habilitation

Habilitation and training should be provided to prevent regression and unreasonable restraint and improve the ability of individuals to exercise their liberty interests. More particularly, the facilities should:

1. Develop and implement individualized habilitation programming directly matched to the individual's goals, interests, needs, and lifestyle preferences.

2. Formalize planning protocols, policies and procedures for use throughout the facilities.

3. Provide staff training on the development of individualized plans and their implementation.

4. Monitor and analyze the efficacy of the individualized planning and implementation process. Each individualized plan should have outcome measures that specify action steps and/or training strategies, and related target dates and responsible staff. Revise programming, as appropriate, based on outcomes.

K. Serving Institutionalized Persons In The Most Integrated Settings Appropriate To Their Needs

Every facility resident should be professionally assessed to determine whether continued placement

in the facility constitutes the most integrated setting appropriate to meet the individual's needs. More particularly, the facilities should:

1. Develop and implement comprehensive, formal guidelines, policies and procedures for transition planning. These should include, at a minimum, target dates, measurable outcomes, training and transition strategies, and responsible staff.

2. Assess the specific characteristics of the most appropriate setting and support needs for each individual at each facility. Assessments (for new admissions) should be done at admission. Periodically update the assessments for individuals who remain at the facility for extended periods of time.

3. If it is determined that a more integrated setting would appropriately meet the individual's needs, promptly develop and implement, with appropriate consent, a transition plan that specifies actions necessary to ensure a safe, successful transition from the facility to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames.

4. Ensure that consent decisions are fully informed.

L. Record Keeping

Individual records should be accurate, current, complete and organized in a manner allowing relevant information to be quickly identified. More particularly, the facilities should:

1. Implement quality assurance/fidelity review procedures to ensure, through frequent, random reviews, that individuals' medical charts and other records are accurate, complete and current. Where the review identifies record keeping deficiencies, these should be monitored to ensure that adequate corrective action is taken to limit their reoccurrence.

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The collaborative approach that the parties have taken thus far has been productive, as both Glenwood and Woodward have exhibited improvements since our investigation began. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding these facilities.

We will forward our expert consultants' reports under separate cover. Although their reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or to otherwise protect the rights of Woodward and Glenwood residents, 49 days after the receipt of this letter. 42 U.S.C. § 1997b (a)(1). Accordingly, we will soon contact State officials to discuss in more detail the measures that the State must take to address the deficiencies identified herein.

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: The Honorable Thomas Miller
Attorney General
State of Iowa

Dr. Michael J. Davis
Superintendent
Woodward State Resource Center

Dr. William Campbell
Superintendent
Glenwood State Resource Center

Ms. Jessie Rasmussen
Director
Iowa Department of Human Services

Steven M. Colloton, Esq.
United States Attorney
Southern District of Iowa

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1. We have assigned random initials to the Woodward and Glenwood residents mentioned herein to protect their privacy. In a separate transmittal, we are providing a schedule through which these individuals can be identified.