STATE OF WISCONSIN

BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

- -

In the Matter of a Petition of

DISTRICT 1199W/UNITED PROFESSIONALS FOR QUALITY HEALTH CARE

Involving Certain Employes of

STATE OF WISCONSIN (PROFESSIONAL-PATIENT CARE)

- -

Case 118
No. 42277
SE-5
Decision No. 26758

Appearances:

Ms. Kathryn Schroeder, Organizer, 1650 Monroe Street, Madison, Wisconsin 53711-2021, appearing on behalf of Petitioner District 1199W.

Ms. Renae Bugge, Employment Relations Specialist, Division of Collective Bargaining, Department of Employment Relations, 137 East Wilson Street, Madison, Wisconsin 53707-7855, appearing on behalf of the State of Wisconsin.

Lawton and Cates, S.C., by Mr. Richard V. Graylow, 214 West Mifflin Street, Madison, Wisconsin 53703-2594, appearing on behalf of the Intervenor Union, Wisconsin State Employees Union, AFSCME, District Council 24, AFL-CIO.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER CLARIFYING BARGAINING UNIT

District 1199W/United Professionals for Quality Health Care, having filed the instant petition with the Wisconsin Employment Relations Commission on May 22, 1989, requesting that the Commission clarify the certified collective bargaining unit consisting of Professional-Patient Care employes by determining whether approximately 40 Qualified Mental Retardation Professionals (QMRPs) employed at the State of Wisconsin's three Centers for the Developmentally Disabled (DD Centers) should be included in said Professional-Patient Care Unit; and Wisconsin State Employees Union having intervened in the proceedings; and hearing having been held in abeyance pending possible settlement; and thereafter, a pre-hearing conference having been held on November 1, 1989 at Madison, Wisconsin, at which all parties were present and at which all parties waived issuance of a written memorandum recounting the events of said pre-hearing conference; and a hearing having been scheduled for October 17 and 18, 1989 and postponed for good cause until November 17, 1989 when hearing was held at Madison, Wisconsin, before Examiner Sharon Gallagher Dobish, a member of the Commission's staff; and a stenographic transcript of the proceedings having been made and received on December 7, 1989; and all briefs having been received and exchanged by the Examiner by February 19, 1990; and the Commission having considered all of the evidence and arguments herein and being fully advised in the premises, makes the following

FINDINGS OF FACT

1. That the State of Wisconsin, hereafter the State, is a political entity, employing various employes in the operation of the State's business, and in that regard the State has entered into various collective bargaining agree-ments with various certified collective bargaining representatives which are the exclusive representatives of employes in appropriate collective bargaining units, among them being the certified units known as the Professional-Patient Care Unit, (PPCU) currently represented by Petitioner District 1199W and the Professional-Social Services Unit (PSSU) currently represented by Intervenor WSEU; that the Department of Employment Relations is the designated bargaining representative of the State, and the employes therein are charged with the responsibility of negotiating and administering the collective bargaining agreements entered into by the State; and that the offices of said Department are located at 137 East Wilson Street, Madison, Wisconsin 53707-7855.

2. That District 1199W/United Professionals for Quality Health Care, hereafter Petitioner, is a labor organization representing employes for the purpose of collective bargaining with offices located at 1045 East Dayton Street, Room 210, Madison, Wisconsin 53703; that Petitioner was certified as the exclusive collective bargaining representative of employes employed in the State's Professional-Patient Care bargaining unit pursuant to Dec. No. 16765-A (WERC, 3/79), described therein as follows:

". . . all classified employes in the employ of the State of

> Wisconsin engaged in the profession of Patient Care, but excluding limited term employes, confidential employes, supervisory employes, managerial employes, and all other employes . . .";

that the effective collective bargaining agreement between Petitioner and the State lists those positions included in the bargaining unit, as follows:

ARTICLE I

Scope of the Agreement

> This Agreement relates to classified employes of the State of Wisconsin in the Professional Patient Care Unit as defined by the Wisconsin Employment Relations Commission Certification, Case CXVIII, No. 23858, SE-86, Decision No. 16765-A, dated March 8, 1979 and as amended by the Wisconsin Employment Relations Commission.

ARTICLE II

Union Recognition

Section 1 Recognition and Union Security

> The Employer recognizes District 1199W/United Professionals for Quality Health Care as the exclusive collective bargaining agent for all employes in the following classifications:

Classification	Salary Range
Dietitian 1	11-02
Dietitian 2	11-04
Dietitian 3	11-06
Handicapped Childrens Specialist 1	11-07
Handicapped Childrens Specialist 2	11-08
Health Education Specialist 1	11-04
Health Education Specialist 2	11-06
Health Education Specialist 3	11-07
Nurse Clinician	11-06
Nursing Consultant 1	11-06
Nursing Consultant 2	11-08
Nursing Consultant 3	11-09
Nursing Education Consultant 1	11-07
Nursing Education Consultant 2	11-08
Nursing Instructor 1	11-06
Nursing Instructor 2	11-07
Nursing Specialist	11-07
Public Health Educator 1	11-04
Public Health Educator 2	11-06
Public Health Educator 3	11-07
Public Health Nurse 1	11-05
Public Health Nurse 2	11-07
Public Health Nurse 3	11-08
Public Health Nutritionist 1	11-05
Public Health Nutritionist 2	11-07
Public Health Nutritionist 3	11-08
Registered Nurse 1	11-03
Registered Nurse 2	11-04
Registered Nurse 3	11-05
Registered Nurse 4	11-07
Therapies Consultant	11-07
Therapist 1	11-03
Therapist 2	11-04
Therapist 3	11-05

> Employes excluded from the collective bargaining unit are all limited term, project, sessional confidential,

supervisory, and managerial employes.

All employes covered by this Agreement are in the classified service of the State of Wisconsin as listed in the certification for this unit by the Wisconsin Employment Relations Commission as set forth in this Agreement.

The parties will review all new classifications relating to this unit and if unable to reach agreement as to their inclusion or exclusion from the bargaining unit shall submit such classifications to the Wisconsin Employment Relations Commission for final resolution.

3. That Wisconsin State Employees Union, AFSCME, District Council 24, AFL-CIO, hereafter WSEU, is a labor organization representing employes for the purpose of collective bargaining with offices located at 5 Odana Court, Madison, Wisconsin 53719; that WSEU was certified as the exclusive collective bargaining representative of employes employed in the State's Professional-Social Services bargaining unit pursuant to Dec. Nos. 11322-F and 11323-F (WERC, 11/73), described therein as follows:

> all classified employes in the employ of the State of Wisconsin engaged in the profession of Social Services, excluding limited term employes, confidential employes, supervisory employes, managerial employes, and all other employes;

that the effective collective bargaining agreement between WSEU and the State lists those positions included in the Professional-Social Services bargaining unit as follows:

ARTICLE 1

Scope of the Agreement

1/1/1 This Agreement relates only to classified employes of the State of Wisconsin in the appropriate collective bargaining unit as defined by the Wisconsin Employment Relations Commission certification Cases IX, X and XI, Nos. 15583 and 15584, SE-44, 45, 46, Decision Nos. 11243, 11244 and 11245, dated August 25, 1972 and Case LXXIV, No. 19548, SE-75, dated January 9, 1976, and Cases VIII and XIV, Nos. 15582 and 15838, SE-43 and 49, Decision No. 11322-F and 11323-F, and Case LX, No. 18944, SE-70, Decision No. 13455.

1/1/2 This Agreement recognizes five separate bargaining units. Each provision of this Agreement applies to all five bargaining units unless specified otherwise. The coverage of this Agreement shall be extended by the parties when mutually agreed to by the Employer and the Union to include employes in the classified service of the State of Wisconsin in additional appropriate collective bargaining units represented by the Wisconsin State Employees Union as certified by the Wisconsin Employment Relations Commission.

. . .

2/1/6 PROFESSIONAL SOCIAL SERVICES (PSS)

Classification	
Area Services Spec. 1	1
Area Services Spec. 2	2
Area Services Spec. 3	3
Area Services Spec. 4	4
Area Services Spec. 5	5
Area Services Spec. 6	6
Chaplain 1	4
Chaplain 2	5
Chaplaincy Ed. Coord.	6
Client Services Asst. 1	25
Client Services Asst. 2	26
Client Services Asst. 3	27
Client Services Asst. 4	28
Disability Deter. Spec. 1	2
Disability Deter. Spec. 2	4
Disability Deter. Spec. 3	5
Disability Deter. Spec. 4	6
Equal Rights Officer 1	3
Equal Rights Officer 2	5
Equal Rights Officer 3	6
Equal Rights Officer 4	7
Ind. & Labor Trng. Coord. 1	4
Ind. & Labor Trng. Coord. 2	5
Ind. & Labor Trng. Rep. 1	2
Ind. & Labor Trng. Rep. 2	3
Ind. & Labor Trng. Rep. 3	4

Title	Grade
Job Service Analyst 1	4
Job Service Analyst 2	5
Job Service Analyst 3	6
Job Service Analyst 4	7
Job Service Counselor 1	2
Job Service Counselor 2	3
Job Service Counselor 3	4
Job Service Counselor 4	5
Job Service Counselor 5	7
Job Service Specialist 1	2
Job Service Specialist 2	3
Job Service Specialist 3	4
Job Service Specialist 4	5

Title	Grade
Labor Market Analyst 1	2
Labor Market Analyst 2	3
Labor Market Analyst 3	4
Labor Market Analyst 4	5
Medical Record Librarian	4
Medical Records Consultant	7
Parole Board Member	9
Psychological Serv. Assoc. 1	2
Psychological Serv. Assoc. 2	4
Psychologist 1	4
Psychologist 2	6
Psychologist 3	7
Psychologist 4	8
Psychologist 5	9
Psychologist 6	10
Psychologist 1 Doctorate	4
Psychologist 2 Doctorate	6
Psychologist 3 Doctorate	7
Psychologist 4 Doctorate	8
Psychologist 5 Doctorate	9
Psychologist 6 Doctorate	10
Recreation Leader 1	1
Recreation Leader 2	2
Social Serv. Spec. 1	6
Social Serv. Spec. 2	7
Social Serv. Spec. 3	8
Social Worker 1	2
Social Worker 2	4
Social Worker 3	5
Unempl. Benefit Analyst 1	4
Unempl. Benefit Analyst 2	5
Unempl. Benefit Analyst 3	6
Unempl. Benefit Analyst 4	7
Unempl. Benefit Spec. 1	2
Unempl. Benefit Spec. 2	3
Unempl. Benefit Spec. 3	4
Unempl. Benefit Spec. 4	5
Unempl. Benefit Spec. 5	6

Unempl. Contrib. Spec. 1	2	Voc. Rehab. Counselor 1	2
Unempl. Contrib. Spec. 2	3	Voc. Rehab. Counselor 2	4
Unempl. Contrib. Spec. 3	4	Voc. Rehab. Counselor 3	5
Unempl. Contrib. Spec. 4	5	Voc. Rehab. Spec. 1	6
Veterans Claims Officer 1	2	Voc. Rehab. Spec. 2	7
Veterans Claims Officer 2	3	Voc. Rehab. Spec. 3	8
Veterans Counselor 1	2	Volunteer Coordinator	3
Veterans Counselor 2	4		

2/1/8 Employes excluded from these collective bargaining units are all office professional, (except Professional Social Services employes), sessional, confidential, limited term, project, management, supervisory and building trades-craft employes. All employes are in the classified service of the State of Wisconsin as listed in the certifications by the Wisconsin Employment Relations Commission as set forth in this Section.

4. That prior to 1974, there were no Qualified Mental Retardation Professionals (QMRPs) employed by the State; that prior to 1974, the State ran its Developmentally Disabled (DD) Centers as skilled nursing homes so that the State could receive medical assistance from the Federal government; that in 1974, the Federal government enacted rules to govern the operation of Immediate Care Facilities for the Mentally Retarded (ICFMR); that the State thereafter determined that it should run its DD Centers not as skilled nursing homes but as ICFMR's; that as a result of this decision, the State was then locked into a set of Federal codes dictating what ICFMR's must offer in terms of outcomes for the residents of each facility, and the Federal code also required that the State draft, adopt and implement its own State codes for ICFMR's; that the State ICFMR code (known as H-134) was thereafter adopted and it was most recently revised in 1988; that the Federal ICFMR code and regulations have been revised from time to time since 1974; that the Federal ICFMR code created a concept whereby an experienced and trained employe in the area of mental retardation would manage, integrate, coordinate and monitor the care and services provided to each ICFMR resident and, on a regular basis, create and revise a plan of care for each resident, setting goals and noting achievements; that such an employe would also act as an advocate for each resident so that optimum outcomes and progress could be achieved for and by each ICFMR resident over time; that this concept eventually evolved into the current QMRP duties and position and, as time passed, Federal surveyors of ICFMR's began to look for QMRPs to be employed to fill the above-described role at these institutions; that the Federal ICFMR code does not now nor has it ever required that State ICFMR institutions employ QMRPs, but the Federal code has consistently required that high levels of services be maintained which would positively impact on each DD resident; that over time, the QMRP duties and responsibilities became so intense and complex that rather than continue to assign QMRP duties to its existing experienced professional DD Center employes in the Professional-Patient Care unit, the State created a special position of QMRP to be employed at its DD Centers; that the State placed the QMRP positions in a Professional-Fiscal and Staff Services bargaining unit, which no labor organization currently represents; and that the Professional-Fiscal and Staff Services Unit currently includes positions such as:

Program and Planning Analyst
Educational Services Assistant
Administrative Assistant
Management Information Specialist
Tax Representative
Special Agent
Auditor
Property Assessment Specialist
Audit Specialist
Community Services Specialist
Account Specialist
Motor Vehicle Program Specialist
Public Information Officer
Training Officer
Accountant
Bank Examiner
Real Estate Agent
Printing Technician
Health Care Rate Analyst
Purchasing Agent

Purchasing Assistant
Savings and Loan Examiner
Special Tax Agent
Trust Fund Specialist
Public Defender Investigator
Credit Union Examiner
Insurance Examiner
Tax Conferee
Emergency Government Specialist
Equal Opportunity Specialist
Publications Editor
Consumer Credit Examiner
Excise Tax Agent

5. That the State currently maintains three Centers for the Developmentally Disabled (DD Centers) at three separate locations; that the State maintains its Northern Center at Chippewa Falls, Wisconsin, its Central Center at Madison, Wisconsin and its Southern Center at Union Grove, Wisconsin; that QMRPs were first employed in the State's Northern and Southern DD Centers sometime during the early to mid-1980's; that QMRPs were first employed at the State's Central Center approximately two years ago to help assure that the Central Center achieved the outcomes required by the Federal code; that in order to determine whether both ICFMR State and Federal codes and regulations are being complied with, the State employs employes on survey teams who analyze and survey the entire DD facility for purposes of continued licensure and to determine whether residents are receiving the level of care required by law; that the members of these survey teams are not employed by any State facility but rather, they are employed by the Wisconsin Department of Health & Social Services, Division of Health, Bureau of Quality Compliance; that as a general rule these survey teams consist of a Nursing Consultant, a QMRP (who is an RN), a Physical Environment employe (usually an Engineer), a Pharmacist, a Dietician and a Sanitarian; that the current Federal ICFMR code is issued with guidelines for Federal surveyors who are charged with the responsibility to determine whether an ICFMR facility should continue to be licensed and, therefore, continue to receive Federal funding; that the guidelines indicate that the Federal surveyors should apply, among other things, the following probes to each survey:

> <u>Section 483.430(a) PROBES</u>:
> Are . . . QMRP functions actually being carried out, or is paperwork simply reviewed?
>
> Are timely modifications of unsuccessful programs or development of programs for unaddressed, but significant needs made or ensured by the QMRP function?
>
> Are program areas visited and are performance and problems of individuals discussed?
>
> Does the plan flow from only the original diagnosis/assessment? Does it take into consideration interim progress on plans and activities?
>
> Is there evidence that collected data are systematically recorded and analyzed to justify changes in programs?
>
> Does the QMRP make recommendations and requests on behalf of individuals? How does the facility respond to these requests?;

that the Federal Surveyor's Guidelines also describe the type of professional program services needed to implement the active treatment program defined by each resident's Individual Program Plan (IPP) as follows:

> <u>Section 483.430(b)(1) GUIDELINES</u>:
> For an active treatment program to be responsive to the individual's unique needs, there must be a foundation of competent professional knowledge that can be drawn upon in the implementation of the interdisciplinary team process. Individuals with developmental deficits will require initial, temporary, or ongoing services from professional staff, knowledgeable about contemporary care practices associated with these areas. A special mention needs to be made that care be taken not to provide individuals with services that are <u>not</u> needed (e.g., if an individual is basically healthy and not on medication, then the individual should not be loaded up with health and health related services).
>
> The needs identified in the initial comprehensive functional assessment, as required in Sec. 483.440(c)(3)(v), should guide the team in deciding if a particular professional's further involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis.
>
> Since such needed professional expertise may fall within the

purview of multiple professional disciplines, based on overlapping training and experience, determine if the facility's delivery of professional services is adequate by the extent to which individual's needs are aggressively and competently addressed. Some examples in which professional expertise may overlap include:

*Physical development and health - nurse (routine medical or nursing care needs that do not interfere with participation in other programs); physician, physician assistant, nurse practitioner (acute major medical intervention, or the treatment of chronic medical needs which will be dependent upon an individual's success or failure in other treatment programs).
*Nutritional status - nurse (routine nutritional needs that do not affect participation in other programs); nutritionist or dietitian (chronic health problems related to nutritional deficiencies, modified or special diets).
*Sensorimotor development: physical educators, adaptive physical educators, recreation therapists, (routine motor needs involving varying degrees of physical fitness or dexterity); special educators or other visual impairment specialists (specialized mobility training and orientation needs); occupational therapist, physical therapist, physiatrist (specialized fine and gross motor needs caused by muscular, neuromuscular, or physical limitations, and which may require the therapeutic use of adaptive equipment or adapted augmentative communication devices to increase functional independence); dietitians to increase specialized fine and gross motor skills in eating.
*Affective (Emotional) development): special educators, social workers, psychologists, psychiatrists, mental health counselors, rehabilitation counselors, behavior therapists, behavior management specialists.
*Speech and language (communication) development: speech-language pathologists, special educators for people who are deaf or hearing impaired.
*Auditory functioning: audiologists (basic or comprehensive audiologic assessment and use of amplification equipment); speech-language pathologists (like audiologists, may perform aural rehabilitation); special educators for individuals who are hearing impaired.
*Cognitive development: teacher (if required by law, i.e., school aged children, or if pursuit of GED is indicated), psychologist, speech-language pathologist.

*Vocational development: vocational educators, occupational educators, occupational therapists, vocational rehabilitation counselors, or other work specialists (if development of specific vocational skills or work placement is indicated).

*Social Development: teachers, professional recreation staff, social workers, psychologists (specialized training needs for social skill development).

*Adaptive behaviors or independent living skills. Special educators, occupational therapists.

6. That at the Southern DD Center, there are a total of approximately 508 residents organized into five units (between 80 and 125 residents per unit) by type of resident and proximity; that at Southern, the State employs more than 900 employes to care for the residents there; that the resident population is primarily made up of mentally retarded adults (that is, residents over age 21) whose retardation levels range from profound to moderate, with most of them being severely to profoundly retarded; that at Southern, there are approximately 20 to 25 clients who are considered children because they are under the age of 21; that in addition to the buildings which house residents, Southern Center has an administration office building which also houses some apartments for employes, as well as a 30-bed correctional facility for females; that at Southern, the following 14 QMRPs are currently employed who possess the educational backgrounds listed next to their names:

Southern Wisconsin Center

Kristine Adams	Registered Nurse
Margaret Epping	B.A. in Social Work
Peter Etube	M.S.W.
Jean Grabarec	Registered Nurse
Gerardus Heijnen	Registered Nurse
Audrey Johnson-Methu	Teacher
Debra Mayo	Registered Nurse
Bob Mitchell	Teacher

Joyce Narveson	Registered Nurse
Barb Rau	Music Therapist
Thomas Redding	B.S. in Therapeutic Rec.
Mary Beth Sowinski	Teacher
Norman Stougaard	M.S.W.
Colleen Uhlenhake	B.S. in Therapeutic Rec.;

that at Southern Center, as well as at its other DD Centers, the State tries to maintain a ratio of one QMRP to 40 residents; that at Southern, the QMRPs report to the Director of Residential Services, Patricia Dolan, a Social Services Supervisor 2 since the Lead QMRP position (which should be occupied by an Administrative Assistant 5) is currently vacant; that also reporting to Ms. Dolan are Unit Directors who are also Social Services Supervisor 2 employes, and Ms. Dolan reports directly to the Acting Director of the Southern Center, Marlys Griffiths (who occupies an Institutional Superintendent 3 position).

7. That at Northern Center, the State cares for approximately 20 mentally retarded children (as defined above) while the remainder of the residents at Northern, approximately 480, are mentally retarded adults; that there are 13 buildings at Northern, some of which are 100 years old, ten buildings are resident buildings, one is a power plant, one is a laundry and another is an education building, all situated on a 400- to 500-acre site; that the resident buildings house varying numbers of residents, from 50 to 100 and up to 240 residents; that the State employs approximately 890 employes at Northern to care for the residents there; that the following 12 QMRPs are currently employed at Northern who possess the educational backgrounds listed next to their names:

Northern Wisconsin Center

Brenda Balsiger	Registered Nurse
Janet Eakins	Music Therapist
Mary Eckwright	Registered Nurse
Rae Ann Hayden	M.S. in Voc. Rehabilitation
Lynda Koeller	Registered Nurse
Donna Meyer-Klick	Recreation Therapist
Deanne Millcamp	Registered Nurse
Kathleen Molkentin	B.S. in Elementary Ed.
Barbara Paterick	Teacher
James Reppert	Teacher
Jill Schultz	Recreation Therapist
Rebecca Stein	Teacher-Elementary Ed.;

that at Northern, the QMRPs report directly to both Unit Director Donna Campbell (a Social Services Supervisor 2) and to QMRP Coordinator Sharon Allemang (an Administrative Assistant 5); that the QMRP Coordinator, in turn, reports directly to the Acting Director of the Northern Center, Barb Sandholm (whose educational background is in nursing); that Unit Director Campbell is to report directly to the Director of Care and Treatment (an Institutional Treatment Director 3), which latter position is currently vacant; that the Director of Care and Treatment is expected to report to the Director of the Northern Center; that also reporting to Unit Director Campbell are the following staff: Program Staff (including one Physician, one Psychologist, one Social Worker, four Teachers and two Recreational Therapists), a Nursing Supervisor and four RN's, six Institutional Aide 5 employes, a number of Institutional Aides 1 and 2 and seven LPN's; that as a general rule and specifically at both Southern and Northern Centers, the QMRPs have no employes who formally report to them, and the QMRPs are not considered to be supervisors within the State system.

8. That the Central DD Center serves approximately 580 mentally retarded residents, 300 of whom are classified as children and the remainder are mentally retarded adults; that some of the residents at Central Center have severe medical problems beyond their developmental disabilities, and the State places such residents at Central because there is a State licensed hospital on the grounds where these residents can be cared for more easily; that the State employs approximately 1,000 employes at Central to serve this resident population, 14 of whom are QMRPs; that all buildings at Central were built between 1965 and 1969; that there are eight resident buildings, a food service building, a hospital building and some out-buildings, all of which are connected by underground tunnels at Central; that the disability levels of the residents at Central are generally higher than those of the residents at the other Centers; that at the Central Center, the State wishes to eventually employ an Administrative Assistant 5 who will act as the QMRP Coordinator and who will report directly to James Schmiedlin (a Social Services Supervisor 2) who is now Director of Special Programs and who is currently acting as QMRP Coordinator; that Schmiedlin reports to Anthony Bruns (Institutional Treatment Director 3) who is the Director of Resident Programs at Central and whose immediate Supervisor is the Director of the Central Center, Dr. Scheerenberger;

that all QMRPs at Central report directly to Schmiedlin and they have no employes reporting directly to them; that also reporting to Schmiedlin are the following staff: three Music Therapists, three Adapted Physical Education employes (two Teachers, one Therapist), 16 Home Environment and Living Program (HELP) employes (14.5 Institution Aides, 0.5 Psychologist, one Speech Therapist), several transportation services employes (including one Institution Aide, 51 Bus/Van Drivers, Vehicle Maintenance, Driver Testing and Contract Services employes), two Volunteer Services employes, several Recreation Services employes (including two Therapists, one Institution Aide, 31 LTE's, an unknown number of work study individuals and one Area Services Specialist); and that the following 14 QMRPs are currently employed at Central Center who possess the educational backgrounds listed next to their names:

Central Wisconsin Center

Pam Brockner	M.S. in Education
Diane Cullum-Powers	Teacher
Judy Haagensen	Registered Nurse
Carol Krzizike	Registered Nurse
Barb Loye	B.S. in Social Work
Tom McBride	M.S. in Counseling and Guidance
Thora McClain	Speech Therapist
Maxine Nehmer	Recreation Therapist
Marie Peacock	B.A. in Elementary Ed. and Psychology
John Schulist	B.S. in Secondary Ed.
Denise Shampo	M.A. in English
Bev Steinhoff	M.S. in Nursing
Joan Thompson	Registered Nurse
Daniel VanRiper	Recreation Therapist.

9. That within the State employment system, a job class specification generally identifies the duties and responsibilities of a group of similar positions; that, in contrast, a position description identifies the specific duties and responsibilities of a particular position; that as a general rule, the State Center QMRP positions are not counted in the employe staffing patterns at any of the three DD Centers; that the QMRPs work in the same work areas as Nurses Aides, Nurses Aides Supervisors, LPN's, RN's, Psychologists, Recreational Therapists, Occupational Therapists, Physical Therapists, Teachers and MD's; that, as a general matter, QMRPs are not "hands-on" care givers as are Nurses, Nurses Aides and Therapists; that although the QMRPs position descriptions vary somewhat at each of the three DD Centers, they generally perform the same duties and have the same responsibilities in all of the Centers, the exception being that at the Central Center, due to the Center Director's approach and conception of QMRP work, the Central Center position description for QMRPs indicates that QMRPs are expected to perform hands-on work, giving residents direct, personal care and training for 10% of the QMRPs work time; that prior to the instant hearing but after the instant Petition was filed, the State determined that it should reclassify the QMRPs into their own separate classification (out of the Administrative Assistant 4 and 5 classifications); that the State's Draft Classification Concepts for the positions of Mental Retardation Specialist 1 and 2 are, respectively, as follows:

QUALIFIED MENTAL RETARDATION SPECIALIST

Draft Classification Concepts

Qualified Mental Retardation Specialist 1 Pr 1-12

This is the entry level for positions responsible for the coordination and development of individual transdisciplinary program plans and plans of care and for ensuring that continuous active treatment is provided for mentally retarded and developmentally disabled residents in a state institution. Positions at this level work under the limited supervision of a unit director.

Qualified Mental Retardation Specialist 2 Pr-1-13

This is the objective level for positions responsible for the coordination and development of individual transdisciplinary program plans and plans of care and for ensuring that continuous active treatment is provided for mentally retarded and developmentally disabled residents in a state institution. Positions at this level participate in individually designed developmental programming with assigned residents; monitor the delivery of assigned residents' plans

of care; complete periodic comprehensive review of assigned residents' plans of care; monitor and document residents' progress; initiate individual program revisions as necessary; and identify staff training needs on the basis of the above activities. These positions function under the general supervision of a unit director;

that the State's Draft Class Descriptions for the QMRPs 1 and 2, respectively, are as follows:

(Qualified) Mental Retardation Specialist 1

Class Description

Definition:

This is the entry level for positions responsible for the coordination and development of individual transdisciplinary program plans and plans of care and for ensuring that continuous active treatment is provided for mentally retarded and developmentally disabled residents in a state institution. Positions at this level work under the limited supervision of a unit director.

Examples of Work Performed:

Prepare a written summary of the annual staffing and update throughout the year.
Complete an annual summary of each assigned resident's response to his/her individual program plan.
Interpret provisions of the individual plans of care to the implementing staff.
Meet regularly with staff to discuss each assigned resident's response to his/her program.
Monitor records for completion of monthly program reviews.
Document significant changes in each assigned resident's condition or behavior.
Observe each assigned resident in his/her program areas.
Participate in or chair the annual disciplinary staffing.
Monitor completion of progress summaries and treatment needs evaluations for each involved discipline in preparation for the annual staffing or prior to the admission for each assigned resident.
Participate with the transdisciplinary team in developing and/or adjusting a habilitation goal for each assigned resident.
Participate in discussions with shift supervisors in developing and integrating active treatment plans for each assigned resident.
Prepare a written summary of each assigned resident's response to his/her program prior to discharge.

Qualifications:

The qualifications required for this classification will be determined on a position-by-position basis at the time of recruitment. Such determinations will be made based on an analysis of the objectives and tasks performed and by an identification of the education, training, work or other life experience which would provide reasonable assurance that the skills required to perform the tasks and the knowledge required upon appointment have been acquired.

Special Requirement:

Must be a Qualified Mental Retardation Professional (QMRP). This is a professional who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree in a professional category specified in the Federal Register as meeting the QMRP qualifications.

(Qualified) Mental Retardation Specialist 2

Class Description

Definition:

This is the objective level for positions responsible for the coordination and development of individual

transdisciplinary program plans and plans of care and for ensuring that continuous active treatment is provided for mentally retarded and developmentally disabled residents in a state institution. Positions at this level participate in individually designed developmental programming with assigned residents; monitor the delivery of assigned residents' plans of care; complete periodic comprehensive review of assigned residents' plans of care; monitor and document residents' progress; initiate individual program revisions as necessary; and identify staff training needs on the basis of the above activities. These positions function under the general supervision of a unit director.

Examples of Work Performed:

Assure completion of progress summaries and treatment needs evaluations for each involved discipline in preparation for the annual staffing or prior to the admission for each assigned resident.
Chair the annual disciplinary staffing.
Direct the transdisciplinary team in developing and/or adjusting a habilitation goal for each assigned resident.
Provide information and reports to county boards, guardians and other responsible parties as requested.
Provide consultation to shift supervisors in developing and integrating active treatment plans for each assigned resident.
Review goal status, document status and communicate the need for program adjustments.
Identify referral needs of each assigned resident and follow through to assure referrals.
Identify and communicate training needs of staff to shift supervisor or unit director.
Monitor the implementation by all disciplines of consistent goals for each assigned resident.
Prepare a written summary of each assigned resident's response to his/her program prior to discharge.
Participate with the social worker and community services staff to facilitate plan of care integration to the community upon discharge of each assigned resident.
Participate in committees and special projects are (sic) requested by the unit director or mental retardation coordinator.
Provide backup program implementation as directed by unit director.

Qualifications:

The qualifications required for this classification will be determined on a position-by-position basis at the time of recruitment. Such determinations will be made based on an analysis of the objectives and tasks performed and by an identification of the education, training, work or other life experience which would provide reasonable assurance that the skills required to perform the tasks and the knowledge required upon appointment have been acquired.

Special Requirement:

Must be a Qualified Mental Retardation Professional (QMRP). This is a professional who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree in a professional category specified in the Federal Register as meeting the QMRP qualifications.

that the Professional-Patient Care unit currently includes the position of Handicapped Children's Specialist; and that the class description for the Handicapped Children's Specialist 2 position is as follows:

Handicapped Childrens Specialist 2

Class Description

Definition:

This is highly responsible and technical planning and consultative work performed in a particular area

of specialization. Positions in this class are located in the central office and serve as the department expert in the specialty area. Expertise is applied both internally within the department and externally to the profession involved. The work is performed under the broad policies of the division with latitude for independent action, initiative, and judgment. Review of programs is limited to after the fact reviews and the effectiveness of the program. Employes in this class interpret policy, recommend changes in policy, and initiate new programs. In the department, the primary responsibilities are consultation in the specialty area, and staffing of multi-discipline clinics. In addition, employes in this class provide consultation to outside agencies and are expected to publish materials concerned with the specialty area in order to enhance the profession, and their level of expertise.

Areas of Specialization:

Pediatrics, Occupational Therapy, Physical Therapy, Medical Social Work, or comparable specialty.

Examples of Work Performed:

Serve as a consultant in area of specialty to handicapped childrens workers, orthopedic schools, local public health nurses, physical therapists, and other professionals concerned with the physically handicapped child's medial care and treatment.
Make team visits throughout the State with out Bureau consultants and handicapped childrens field representatives for the purpose of indirectly assisting families in care and treatment of the handicapped child.
Make home visits when indicated, ordinarily with handicapped childrens field representatives.
Organize multi-discipline clinics for children throughout the State along with the Bureau Medical Director and Handicapped Childrens Program Supervisor Workers.
Participate as a team member in the Bureau multi-discipline clinics.
Consult with physicians concerning management of patients about whom there is mutual concern.
Plan inservice training sessions for appropriate staff members as well as organizing and conducting workshops and institutes for different professionals dealing with handicapped children throughout the State.
Prepare written material relating to specialty such as bibliographies, bulletins and articles for Bureau Memorandum, and other professional publications.
Prepare articles and bulletins for parents of handicapped children.
Cooperate in developing new programs and establishing agency policies.

Qualifications

Required Knowledges, Skills and Abilities

Thorough knowledge of the principles of the special field and their application to the problems of handicapped children and the process of consultation.
Thorough knowledge of the place of the clinical specialty as it relates to community health and welfare services.
Extensive knowledge of teaching methods and of source materials for use in educational programs.
Ability to communicate and cooperate with individuals, groups, and agencies.
Ability to plan, organize, and conduct programs and conferences.
Ability to express ideas in a clear and concise manner, both orally and in writing.

Training and Experience:

Such training and experience as may have been gained through graduation from a university or college with a major in Pediatric Nursing, Occupational Therapy, Physical Therapy, Social Work, or related Public Health specialty as it applies to Handicapped Children, and one year of experience equivalent to the Handicapped Childrens Specialist I; or an equivalent combination of training and experience.

10. That pursuant to a recent Job Opening Announcement, the qualifications, experience and training necessary for an individual's hire as a State QMRP are generally as follows:

Direct the delivery of each resident's Individual Plan of Care to ensure active treatment, identify treatment needs, interpret provisions of the assigned resident at least monthly to ensure appropriate effective intervention, monitor resident record for completion of monthy (sic) and quarterly program/ progress assessments by treatment team, meet with supervisosry (sic) staff at least weekly to discuss individual client progress/lack of progress, emphasizing records and reports. Complete monthly progress report forms and discuss residents with QMRP Coordinator and Unit Director focusing on problem areas detected. Assure completion of progress summaries and treatment needs evaluations in preparation for each staffing meeting from each involved discipline. SPECIAL REQUIREMENT: Must have at least one year of experience working directly with persons with mental retardation or other developmental disabilities; AND is one of the following: a Doctor of medicine or osteopathy or a Registered Nurse registered as professional nurse in the State of Wisconsin; a Physical Therapist with at least a Bachelor's degree and eligible for licensure in the State of Wisconsin; an Occupational Therapist with at least a Bachelor's degree and eligible for registration by the American Occupational Therapy Association; a Psychologist with a Master's degree in psychology from an accredited school; a Social Worker with a Master's degree from a school of social work accredited or approved by the Council on Social Work Education OR a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education; a Speech-Language Pathologist or Audiologist with a Bachelor's degree and eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association OR meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification; a Recreation Specialist with a Bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education; a Dietitian with a Bachelor's degree and eligible for registration by the American Dietetics Association; a Human Services Professional with a Bachelor's degree in a human services field including but not limited to: sociology, special education, rehabilitation counseling and psychology;

that these requirements are essentially the same as those required by the Federal and State ICFMR code, regulations and accompanying guidelines, if any; that as a practical matter, State QMRPs have come from social work, teaching, nursing, therapy and other human services educational backgrounds, training and experience; that each of the three State DD Centers employs QMRPs from a variety of educational backgrounds, and the State does not favor any one or more of these educational backgrounds over others for purposes of hire; that as a practical matter, the following description of the QMRP Program purpose and philosophy, although only formally in place at the Northern Center, generally applies to the QMRP Programs at all of the State's DD Centers:

PURPOSE In accordance with Federal and State ICF/MR regulations, the Qualified Mental Retardation Professional (QMRP) is responsible for integrating, coordinating, and monitoring each client's active treatment program. The QMRP interprets provisions of the Individual Program Plan (IPP) to implementing staff, ensures staff training for the IPP and facilitates timely adjustments to the Individual Program Plan as client's needs change.

PHILOSOPHY The QMRP's (sic) provide quality assurance for

continuous active treatment at Northern Wisconsin Center. Active treatment is a dynamic concept recognizing that severely developmentally disabled people can learn, grow, and change. This process emphasizes constant participation in normalized, age-appropriate activities, therapies, and experiences throughout the day that allow clients to develop to their fullest potential. Necessary to implementation of active treatment are professionally developed and supervised individual programs directed toward acquisition of developmental, behavioral, and social skills that are needed for maximum client independence. For dependent clients where no further positive growth is demonstrable, programs directed toward prevention of regression or loss of skills become active treatment.

Each client must have an individual post-institutionalization plan which includes provision for appropriate services, protective supervision, and follow-up services in a less restrictive environment. Active treatment means there is competent interaction of staff with clients served at all times in formal and informal settings. This process must be identifiable in documentation and observable in daily practice;

that although the QMRPs at Northern Center conduct monthly, quarterly and annual staffings regarding each resident while the other State DD Centers perform only quarterly and annual staffings, the following policy statement regarding QMRP annual staffings at the Northern Center generally applies to all such staffings at all of the State's DD Centers:

POLICYEvery client residing at Northern Wisconsin Center shall have a Comprehensive Plan of Care to assist the client in attaining or maintaining his/her optimal physical, emotional, intellectual, social and vocational functioning. The Comprehensive Plan of Care, detailing active treatment provision, shall be developed by an appropriately constituted Interdisciplinary Team within 30 days after the client's admission to Northern Wisconsin Center. The Plan shall be reviewed at least annually by an appropriately constituted Interdis-ciplinary Team, representative of the professions and service areas relevant in each particular case and monthly by the Qualified Mental Retardation Professional (QMRP). The Plan of Care and the review will meet the standards as described in the Federal Register Title XIX.

The annual staffing is a planning session which includes a discussion of the client's response to their program; post-institutional plan; identification of client strengths and needs; and the development of goals, objectives and teaching strategies.

During the staffing, consideration needs to be given to client rights, placement options, developmental progression of objectives, client choices and opportunities for learning in a variety of settings.

The Comprehensive Plan of Care is composed of:

1.Discipline assessments, Summaries of Performance, and Client Needs Profile.

2.Individual Program Plan: Habilitation goal, strengths, prioritized needs, integrated goals, objectives and implementors, staffing summary paragraph, and staffing notes. Specific strategies are detailed on the Active Treatment Plans and reviews, Individualized Education Plans, Behavior Active Treatment Plans, or OT/PT Monthly Progress Note.

3.The Individual Service Plan must include care plans and

reviews from medical, nursing, nutrition, social work, and may include occupational and/or physical therapy.

11. That as a practical matter, if the QMRP determines that everything is working properly so that the resident in question will likely reach the goals set in his/her Individual Program Plan (IPP), then even though the method or means by which the resident actually reaches one or more of his/her goals may not be what the QMRP expected or predicted, no change in the IPP is necessary (except to set new and appropriate goals to replace those reached); that on the other hand, if the QMRP determines that the IPP is not working properly for a resident, then the QMRP must be the resident's advocate and take immediate action; that in the Centers where the QMRP has a direct supervisor (such as a QMRP Coordinator) to whom the QMRP normally reports, the QMRP might choose to report his/her finding of inadequate resident care to that supervisor; that additionally or in the alternative, the QMRP may choose to speak directly to the resident's hands-on care givers to discuss and hopefully cure the problem; that the QMRP may also choose to engage in training other staff, or he/she may request that other professional patient care staff train (or re-train) staff to properly assist the resident in reaching the resident's IPP goals; that generally, the QMRPs have the option or authority to determine how they will proceed in the above-described situation; that, however, the QMRPs normal responsibility is not to direct or to supervise other professional staff, but rather, it is to make certain that the services delivered to each resident are needed by the resident and effective to accomplish the three to five major goals that are normally set for each resident in his/her IPP; that QMRPs at the State's DD Centers also generally must arrange and coordinate the quarterly and annual transdisciplinary (or interdisciplinary) team staffing meetings which are held to discuss and revise each resident's IPP and the goals contained therein; that the Transdisciplinary Team (T Team) is normally made up of all professional and non-professional staff who deal with the residents; that generally, the QMRP or the Unit Director runs the staffing meeting regarding a resident, and normally invites the following staff to a trans-disciplinary meeting: Psychologist, any Nurses Aides, LPN's and Nurses who deal with the resident, a Social Worker, Speech Therapist, Recreational Therapist, a Teacher or Vocational Trainer, the resident and his/her parents or family, and a Pharmacist (if the QMRP or Unit Director believes that is necessary); that the QMRP or Unit Director who runs these staffing meetings does not have overall authority to revise or set resident IPP goals -- this authority lies in the T Team as a whole with each member of the team having an equal voice in the ultimate management of each resident's case; and that the Federal code provides that if care for one resident is found inadequate, the entire ICFMR could be decertified, and the DD Center could lose all of its Federal funding.

12. That relevant portions of the State of Wisconsin are organized in the following manner for purposes of budgetary proposals: that the Department of Health and Social Services (H&SS) is headed by a Secretary who is appointed by the Governor with the advice and consent of the State Senate; that beneath the Secretary are Divisions, one of which is the Division of Care and Treatment Facilities (DCTF); that the DCTF is headed by Linda Belton and it is organized into three Sections which are each headed by a Section Assistant Administrator; that the Assistant Administrator for the State's three DD Centers is Gerald Dymond; that the other two DCTF Section Administrators are (respectively) in charge of Management Services and the State's Mental Health Institutes and Wisconsin Resource Center, and these two Sections and their employes are not involved herein; that each DD Center is headed by a Director who reports to Assistant Administrator Dymond; that with regard to the fiscal biennium budget covering the State's three DD Centers, Assistant Administrator Dymond receives instructions on how his budget should be prepared from the State Department of Administration and, in line with past practice and policy, Dymond then directs the Directors of each DD Center to determine a proposed budget cost for the fiscal biennium, assuming that each Center would merely continue current functions and programs without change or improvement; that Dymond also normally requests that Center Directors prepare a separate list of items (costed on a per item basis) which the Directors would like to see added to their budgets to improve resident care, provide for future needs or to establish new or creative programs; that prior to Dymond's promotion to the position, the Assistant Administrator of the DD Centers and his/her supervisors have had a practice of taking suggestions regarding budgetary matters from "the bottom up" so that it is conceivable that any DD Center employe, including the QMRPs, could make a suggestion regarding an improvement or an expenditure for which that Center might ultimately receive approval and funding; that no QMRP has ever made such a suggestion which was ultimately approved and funded; that neither Dymond nor the Center Directors get approval and funding for every program or item they propose in their draft budgets; that after the Center Directors submit their proposed budgets to Dymond, Dymond and Belton (and their superiors) can add to, change and delete from these proposed budgets, since the budgetary process is also a "top down" process as well as a "bottom up" process; that Belton, Dymond and Pahnke (from the State H&SS Office of Policy and Budget) are authorized to defend what ultimately becomes the Division's proposed budget for the DD Centers to the Secretary of H&SS who can then also make any changes, additions and deletions in it that he/she sees fit; that none of the QMRPs has ever

defended the DD Centers' budget before the Secretary of H&SS; that after the Secretary approves the proposed DD Centers' budget, it goes to the H&SS Office of Policy and Budget for approval and then to the Department of Administration for approval before it is presented to the Governor for his changes, if any; that the budget then goes to the Legislature (and its Committees) for consideration; that once the DD Centers' budget is adopted, only Belton, Dymond and a DD Center Director have the authority to transfer money from one expenditure category to a different expenditure category and spend it without further approval; that the QMRPs do not order supplies except, on occasion, from the Centers' internal supplies office, and the QMRPs do not have the authority to otherwise commit any DD Center funds; that as a general rule, if a position requires that an employe spend a significant amount of work time on budgeting duties, such would be described in either the job class specification or position description for that position; and that there is no mention of QMRPs having any significant fiscal or budgetary duties in the job class specifications or position descriptions for the position.

Upon the basis of the above and foregoing Findings of Fact, the Commission makes and issues the following

CONCLUSIONS OF LAW

1. That the incumbents in the position known as Qualified Mental Retardation Professional (QMRP) are not "management employes" within the meaning of Sec. 111.81(13), Stats., and thus are "employes" within the meaning of Sec. 111.81(7), Stats.

2. That the position of Qualified Mental Retardation Specialist (QMRP) is most appropriately placed in the Professional-Patient Care bargaining unit.

Upon the basis of the above and foregoing Findings of Fact and Conclusions of Law, the Commission makes and issues the following

ORDER CLARIFYING BARGAINING UNIT 1/

That the position of Qualified Mental Retardation Professional (QMRP) is hereby included in the Professional-Patient Care bargaining unit.

Given under our hands and seal at the City of Madison, Wisconsin this 24th day of January, 1991.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By ______________________________
Herman Torosian, Commissioner

____
William K. Strycker, Commissioner

I concur in part and
I dissent in part.

____
A. Henry Hempe, Chairman

1/ Please find Footnote 1/ on page 19.

1/ Pursuant to Sec. 227.48(2), Stats., the Commission hereby notifies the parties that a petition for rehearing may be filed with the Commission by following the procedures set forth in Sec. 227.49 and that a petition for judicial review naming the Commission as Respondent, may be filed by following the procedures set forth in Sec. 227.53, Stats.

227.49 Petitions for rehearing in contested cases. (1) A petition for rehearing shall not be prerequisite for appeal or review. Any person aggrieved by a final order may, within 20 days after service of the order, file a written petition for rehearing which shall specify in detail the grounds for the relief sought and supporting authorities. An agency may order a rehearing on its own motion within 20 days after service of a final order. This subsection does not apply to s. 17.025(3)(e). No agency is required to conduct more than one rehearing based on a petition for rehearing filed under this subsection in any contested case.

227.53 Parties and proceedings for review. (1) Except as otherwise specifically provided by law, any person aggrieved by a decision specified in s. 227.52 shall be entitled to judicial review thereof as provided in this chapter.

(a) Proceedings for review shall be instituted by serving a petition therefore personally or by certified mail upon the agency or one of its officials, and filing the petition in the office of the clerk of the circuit court for the county where the judicial review proceedings are to be held. Unless a rehearing is requested under s. 227.49, petitions for review under this paragraph shall be served and filed within 30 days after the service of the decision of the agency upon all parties under s. 227.48. If a rehearing is requested under s. 227.49, any party desiring judicial review shall serve and file a petition for review within 30 days after service of the order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. The 30-day period for serving and filing a petition under this paragraph commences on the day after personal service or mailing of the decision by the agency. If the petitioner is a resident, the proceedings shall be held in the circuit court for the county where the petitioner resides, except that if the petitioner is an agency, the proceedings shall be in the circuit court for the county where the respondent resides and except as provided in ss. 77.59(6)(b), 182.70(6) and 182.71(5)(g). The proceedings shall be in the circuit court for Dane county if the petitioner is a nonresident. If all parties stipulate and the court to which the parties desire to transfer the proceedings agrees, the proceedings may be held in the county designated by the parties. If 2 or more petitions for review of the same decision are filed in different counties, the circuit judge for the county in which a petition for review of the decision was first filed shall determine the venue for judicial review of the decision, and shall order transfer or consolidation where appropriate.

(b) The petition shall state the nature of the petitioner's interest, the facts showing that petitioner is a person aggrieved by the decision, and the grounds specified in s. 227.57 upon which petitioner contends that the decision should be reversed or modified.

. . .

(c) Copies of the petition shall be served, personally or by certified mail, or, when service is timely admitted in writing, by first class mail, not later than 30 days after the institution of the proceeding, upon all parties who appeared before the agency in the proceeding in which the order sought to be reviewed was made.

Note: For purposes of the above-noted statutory time-limits, the date of Commission service of this decision is the date it is placed in the mail (in this case the date appearing immediately above the signatures); the date of filing of a rehearing petition is the date of actual receipt by the Commission; and the service date of a judicial review petition is the date of actual receipt by the Court and placement in the mail to the Commission.

MEMORANDUM ACCOMPANYING FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER CLARIFYING BARGAINING UNIT

POSITIONS OF THE PARTIES

The Petitioner, District 1199W, argued in its initial brief as follows: that since the QMRP position did not exist until 1988, they could not have been placed in the PPCU pursuant to Sec. 111.825(1)(f), Stats.; that the most appropriate bargaining unit in which to place the QMRPs is the PPCU based on an analysis of the community of interest of the QMRPs and members of the PPCU; that as the State and Federal ICFMR regulations and codes use the terms "client," "resident" and "patient" interchangeably, the QMRPs are engaged in the profession of caring for patients, clients or residents as are other members of the PPCU; that the QMRPs work with many PPCU employes in a trans-disciplinary team setting and on a day-to-day basis; that the QMRPs duties and skills are similar and/or comparable to those of PPCU employes; that for example, the QMRPs complete monthly reviews at Northern Center in which they consider and analyze many regular reports created by PPCU employes or which PPCU employes utilize in providing patient care to residents; that 23 of the 40 QMRPs possess skills and backgrounds similar to PPCU employes -- 13 QMRPs are RNs and 10 are Therapists; that only six of the State's QMRPs have backgrounds in disciplines from which Intervenor Union's PSSU members come; that none of the QMRPs have backgrounds in the administration, staff services or budget/ fiscal areas; that the majority of the fields listed by the Federal regulations and code from which QMRPs should come are in the professional patient care field; that the QMRPs perform work similar to employes in several PPCU classifications, such as Nursing Consultants, Public Health Educators and Handicapped Children's Specialists; that the wages of QMRPs (ranging from $12.08 to $17.20), at a PR-13, are similar to the wage ranges of PPCU employes; that some PPCU employes (such as Nursing Consultants) have the flexibility to self-schedule their hours of work, as do QMRPs; that QMRPs share common super-vision with PPCU employes -- at Northern and Central Centers, the QMRPs are supervised by a Social Services Supervisor 2 employe and at Southern Center, the QMRPs are supervised by the Director of Recreational Services (who is an RN), and these supervisors also supervise PPCU employes; that the QMRPs share a common work place, the three DD Centers, with PPCU employes; that Wisconsin public policy, as confirmed by Sec. 111.80(4), Stats., is to ". . . encourage . . . collective bargaining in state employment . . . ." and to assign the QMRPs to the F&SSU, a unit with which they share no community interest, would leave the QMRPs unrepresented, contrary to State policy; that Petitioner also argued that the QMRPs are not managerial employes; that the QMRPs have no significant authority to commit Center resources and they have had no significant role in formulating Center policy; that, in any event, the QMRPs are not engaged "predominantly" in executive or management functions as required by Sec. 111.81(13), Stats., and that the QMRPs are not involved in the formulation, determination or implementation of management policy at a high level of responsibility and to a degree that makes the manager unique from his co-workers; that the recommendations and advice offered by the QMRPs to other employes are not coupled with any authority to compel compliance therewith, as it would be the case were the QMRPs true managers.

Intervenor WSEU argued in its initial brief as follows: that the best placement for QMRPs would be in the PSSU as the work performed, the position and qualifications standards, the job definitions, the qualifications and specific requirements indicate the QMRPs share similar skills, backgrounds and experience, duties, goals and responsibilities with members of the PSSU, as indicated by WSEU's detailed analysis of the Job Specifications for the QMRPs and PSSU positions of Social Workers 1, 2 and 3, Social Services Specialists 1 and 2, and Psychologists 1, 2 and 3; that Intervenor argued that the QMRPs would not be properly placed in the PPCU, as the QMRPs function primarily as case managers (like members of the PSSU) and they are not primarily healers or health care providers (as are PPCU members); that for the QMRPs, as for members of the PSSU, health concerns are only a part -- and a secondary part -- of the QMRPs concerns; that QMRPs, like PSSU members, are devoted to assessing and monitoring the residents' overall treatment plans and all aspects of their existence which impact upon the residents' well-being; that the job definitions for such PPCU positions as Public Health Educators 1 and 2, Dietitians 1, 2 and 3 and Nursing Consultants 1 and 2 demonstrate the differences between PPCU members and the QMRPs; that the QMRPs need not possess specific health care backgrounds which members of the PPCU must possess; that, rather, the QMRPs are required to possess only human services backgrounds and certain experience, like members of the PSSU; that the QMRPs do not belong in the F&SSU and they are not managerial employes, as the State has argued; that the QMRPs, unlike members of the F&SSU, do not primarily work at analyzing raw data and making specific recommendations on administrative, budgetary/fiscal or other supportive staff functions; that neither the QMRP Job Specification nor any other State document indicates that the QMRPs are authorized or paid to perform true administrative/fiscal/ budgetary/staff functions as a significant part of

their duties; that, unlike the QMRPs, other members of the F&SSU have job titles consistent with their administrative/budgetary functions -- Accountant, Auditor, Audit Specialist, Bank Examiner, Insurance Examiner, Real Estate Agent, Planning Analyst, Property Assessor, Purchasing Agent, Taxation Analyst, among others; that the QMRPs are not managerial employes under the Act and therefore, they should not be excluded from any represented unit on that basis; that the QMRPs have no supervisory duties, and their job classification does not fit into the statutory listing of managerial classifications; that the QMRPs ability to self-schedule, by itself, does not require that the Commission find them to be managerial and that many PSSU employes have flexibility in scheduling their work hours; that the QMRPs have no explicit budgetary input or authority and they cannot commit or reassign Center resources on their own.

The State argued in its initial brief that the QMRPs should properly remain in the F&SSU and if the Commission finds that that is an inappropriate unit placement, the QMRPs are managerial employes who should be statutorily excluded from any union representation; that the duties and responsibilities of the QMRPs are similar to those of other F&SSU members; that, in this regard, the QMRPs, like other F&SSU members, are employed in administrative program support areas, performing analytical work as group leaders or lead workers in a professional multi-disciplinary setting; that notably, the QMRPs are not interchangeable with other classifications in the PPCU or the PSSU, since to transfer, promote, bump, layoff employes with an impact upon QMRPs would require employes entering the QMRP job to train and gain experience with mentally retarded before an employe could be employed as a QMRP; that the QMRPs must self-schedule and operate outside the regular hierarchy of the Centers so that they can act as true advocates for the residents and, there-fore, they should not be placed in either the PPCU or PSSU; that the QMRPs are, in any event, managerial employes who should be excluded from any unit; that the managerial status of the QMRPs is based upon their role as Team leaders, their having to report directly to Unit Directors or the Center Director, and their ability to assign staff and to make changes in medical treatment, intervention and education for their clients; that, therefore, the State argued, that the QMRPs exercise functions and responsibilities similar to statutory managers pursuant to Sec. 111.81, Stats.

In its reply brief Petitioner 1199W argued: that the State's argument regarding interchangeability of the QMRPs with other employes is not determin-ative of community of interest and, therefore, the interchangeability factor does not require that the QMRPs be placed in the F&SSU; that if the Commission places the QMRPs in the PPCU, their transfer, promotion, hours of work, demotion and bumping rights will become the subject of collective bargaining and any potential problems could be alleviated thereby; that the QMRPs should not be assigned to the PSSU because QMRPs are essentially health care professionals who deal with a wide range of aspects of the patients' health in managing each patient's case as do PPCU members such as RNs; that the PSSU consists of approximately 32 different job series, only three of which series (Social Workers, Psychologists, Social Services) have some similarities to QMRPs; that the PPCU now has approximately 20 different job series and that the PPCU members have the same required experience caring for DD patients, similar educational backgrounds (both in health care and in social services areas) such that PPCU members are more broadly similar to QMRPs; that in its initial brief, the WSEU unfairly compared selected portions of some PSSU members' job and position descriptions to those of the QMRPs which garnered skewed results.

Intervenor WSEU argued as follows in its reply brief: that the DD clients at the three State DD Centers are not patients, but rather, they are residents; that therefore, QMRPs are not engaged in patient care but are engaged in coordinating and managing each resident's case, similar to the duties that Probation and Parole Agents or Social Workers perform within the PSSU; that the facts indicate clearly that the State's assertions that the QMRPs are super-visory and/or managerial employes are groundless; that the State's argument regarding interchangeability over-emphasizes only one factor in a community of interest analysis, although the QMRPs are more interchangeable with PSSU employes than many other positions might be; that the QMRPs have no community of interest with F&SSU employes contrary to the State's arguments -- that the QMRPs have neither fiscal nor budgetary nor staff direction/ supervisory duties; that the QMRPs are case managers like PSSU employes, demonstrated by comparison of their positions and job descriptions and these similarities require that the QMRPs be placed in the PSSU.

In its reply brief, the State argued that the QMRPs properly belong in the F&SSU based upon the duties and responsibilities of the job as professional patient care employes performing coordination, evaluation and assessment of the needs of DD residents in a multi-disciplinary setting where the QMRPs must be free to relate concerns to management and to oversee each resident's DD program; and that the State pointed out that the QMRPs do not perform fiscal duties but rather they perform staff services duties -- by objectively managing each resident's multi-disciplinary treatment program -- thus justifying their placement in the F&SSU.

DISCUSSION

"MANAGEMENT" STATUS OF QMRPs

Section 111.81(7), Stats., excludes from the definition of "employes" those who are "management employes." The State argues that the QMRPs are "management employes" who are therefore ineligible for inclusion in any bargaining unit. Section 111.81(13), Stats., defines "management" as:

> "those personnel engaged predominately in executive and managerial functions, including such officials as division administrators, bureau directors, institutional heads and employes exercising similar functions and responsibilities as determined by the Commission."

This definition specifically lists certain positions which, by virtue of their placement in the organizational structure, are per se management positions. 2/ In addition, Sec. 111.81(7), Stats., includes within the scope of "management" those employes who engage ". . . predominantly in executive and managerial functions . . . ." Here, it is apparent that the QMRPs are not per se "management" based on their placement in the State's organizational structure. Nor is there any claim the QMRPs are executive. Thus, the question is whether they are "management" because they are engaged ". . . predominately in . . . managerial functions . . ." We have held that "managerial" functions are established by participation in a significant manner in the formulation, determination and implementation of management policy or the effective authority to commit the employer's resources. 3/

As reflected in our Findings of Fact, the QMRPs have no particular authority to commit the State's financial resources. Nor do their duties predominantly involve significant policy functions. While, as professionals and advocates for their clients, QMRPs clearly have a significant role in the provision of care in the DD Centers, their predominant responsibility is to ensure that the policy judgments of others are appropriately carried out. This role in policy implementation is not a "managerial function" under Sec. 111.81(7), Stats. Thus, the QMRPs are not "management" employes.

Unit Placement

When determining which statutorily established bargaining unit is most appropriate for a disputed position, we consider the position's duties, skills, training requirements and working conditions in the context of the statutory bargaining unit descriptions and of the positions already included in existing units. 4/ We seek to place employes in the unit with employes who best match their duties, skills, training requirements and working conditions and with whom they therefore share the strongest community of interest.

2/ State of Wisconsin, Dec. No. 11640-C (WERC, 1/86).

3/ State of Wisconsin, Dec. No. 11885-M (WERC, 11/82).

4/ Dept. of Administration (Fiscal & Staff Services), Dec. No. 15836 (WERC, 9/77); State of Wisconsin, Dec. No. 15103-A (WERC, 5/77).

Consideration of the QMRPs in the context of the Professional-Social Services, Professional-Patient Care, and Fiscal and Staff Service units produces a close question as to whether the QMRPs are most appropriately placed Social Services or Patient Care unit. However, on balance, we are persuaded that placement in the Professional-Patient Care unit is most appropriate.

Several factors play a significant role in our decision.

Importantly, the QMRPs coordinate patient care rather than social services for residents. The draft class description states that the position is responsible for:

> . . . the coordination and development of individual transdisciplinary program plans and plans of care and for ensuring that continuous active treatment is provided for mentally retarded and developmentally disabled residents in a state institution. Positions at this level participate in individually designed developmental programming with assigned residents; monitor the delivery of assigned residents' plans of care; complete periodic comprehensive review of assigned residents' plans of care; monitor and document residents' progress; initiate individual program revisions as necessary; and identify staff training needs on the basis of the above activities. (emphasis added)

. . .

The patient care plan which QMRPs coordinate is developed by an inter-disciplinary team whose membership primarily consists of Professional-Patient Care unit positions. An interdisciplinary team generally consists of the following positions who have the following unit memberships:

A nurse	Patient Care
Psychologist	Social Service
Recreational Therapist	Patient Care
Speech Therapist	Patient Care
Dietary Specialist	Patient Care
Social Worker	Social Service
Pharmacist	Unknown
Occupational Therapist	Patient Care

A majority of the QMRPs have educational backgrounds which are shared by Patient Care unit members. Of the 40 current QMRPs, 23 have nursing or therapist training.

A majority of the professions from which QMRPs can be drawn are Patient Care unit professions. The qualifications for the QMRP position are set by Federal Regulation rather than by the State. The first position listed as appropriate to qualify as a QMRP is doctor. After this profession, the following positions are listed as qualifying as candidates:

1.	Nurse	Patient Care
2.	Occupational Therapist	Patient Care
3.	Assistant Occupational Therapist	Patient Care
4.	Physical Therapist	Patient Care
5.	Assistant Physical Therapist	Patient Care
6.	Psychologist	Social Service
7.	Social Worker	Social Service
8.	Speech Therapist	Patient Care
9.	Recreation Therapist	Patient Care
10.	Dietician	Patient Care
11.	Human Services Professional	Social Service

Contrary to the State's argument, it is therefore also apparent that inclusion of QMRPs in the Professional-Patient Care unit can provide QMRPs and existing unit members with ample opportunity for mobility within the unit.

Prior to the establishment of the formal QMRP position, members of the Patient Care unit performed the QMRP function. Indeed, QMRPs on occasion provide direct hands on care to patients which is independent from their patient care role coordinating and monitoring patient care plans.

Lastly, as indicated in Finding of Fact 9, the Patient Care unit includes a Handicapped Children's Specialist whose duties and training closely match the QMRPs. The Handicapped Children's Specialist, like QMRPs, review and monitor service and care plans for individual patients. Like QMRPs, the Specialists must be familiar with a broad range of professions in order to evaluate the services received by the patients. Thus, like QMRPs, the Specialists perform a multi-disciplinary function.

Given all of the foregoing, we conclude that QMRPs are professional employes engaged in patient care who thus should be included in the Professional-Patient Care unit. While none of the considerations we have discussed is determinative, in combination we are persuaded they demonstrate that QMRPs share the strongest community of interest with employes in the Patient Care unit.

Although Patient Care is the best "match" for the QMRPs, we acknowledge that there are aspects of the QMRP's duties and training requirements which are supportive of placement in the Professional-Social Services unit. However, while WSEU correctly argues that QMRPs can be viewed as "case managers," the case management function is not performed exclusively by Social Service employes. In addition to the Handicapped Children's Specialist discussed earlier herein, the Patient Care positions of Nursing Consultant and Public Health Educators also perform such a role. More importantly, the "case manager" role performed by Social Service employes naturally focuses more on delivery of social services rather than patient care which is the QMRP's focus. Lastly, we note that QMRPs work with approximately 20 different positions currently included in the Patient Care unit but work with employes in only three Social Service unit positions.

Of the options before us, the least persuasive choice is placement in the Fiscal and Staff unit. In Dept. of Administration (Fiscal & Staff Services, Dec. No. 15836 (WERC, 9/77), we noted that "staff" positions provide administrative support and technical expertise for various state functions. Unlike the various positions listed in Finding of Fact 4, QMRPs are providing patient care and patient advocacy rather than technical and administrative support. Their support and oversight role focuses directly on the needs of the recipients of state services not the needs of the state administration. Their "client" is the patient not the Directors of the DD centers.

As to the State's concern about a conflict of interest developing if QMRPs are placed in the Patient Care, we note that Patient Care employes (nurses) performed the QMRP function in the past and there is no evidence that they did not effectively carry out their oversight function over fellow Patient Care employes. We see no reason to believe that such a conflict can emerge. 5/ As to the State's concern about the inability of QMRPs to have mobility if placed within the Patient Care unit, we have previously noted that the training of many QMRPs would seem to provide mobility to both QMRPs and current Patient Care employes. Nonetheless, reviewing the positions currently in the Fiscal and Staff unit, it is apparent that QMRPs within a Patient Care unit will inevitably have more mobility than within the Fiscal and Staff unit which contains no other positions whose training and educational background is comparable to the QMRPs.

Given the foregoing, we have not found our colleague's position persuasive. Assuming arguendo he is correct that some Fiscal and Staff employes perform a multi-disciplinary oversight function, we have previously noted that said role is also filled by current Patient Care employes.

In summary, as discussed earlier, we are convinced that there is a stronger community of interest between QMRPs and Patient Care employes than between QMRPs and Social Service or Fiscal and Staff employes.

Dated at Madison, Wisconsin this 24th day of January, 1991.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By ______________________________
Herman Torosian, Commissioner

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William K. Strycker, Commissioner

5/ See also DePere Schools, Dec. No. 26572 (WERC, 8/90).

Concurring and Dissenting Opinion of Chairman Hempe

I concur with the majority's determination that the Qualified Mental Retardation Professionals are not "management" employes within the meaning of Sec. 111.81(7), Stats. I reach my conclusion for the same reason recited by the majority. While QMRPs provide an indispensable patient care overview, I join my colleagues in finding that the ". . . predominant responsibility (of the QMRPs) is to ensure that the policy judgments of others are appropriately carried out."

From this juncture, however, the only obvious conclusion is that whatever else we do with the Qualified Mental Retardation Professionals is not a perfect solution. Not entirely scaled, feathered, or furred, the position of QMRP defies easy placement into any of the professional bargaining units enumerated in Sec. 111.825(1)(f). Under this circumstance, Commission disagreement as to ultimate bargaining unit disposition of these talented professionals is, perhaps, inevitable.

Three alternatives are urged by the respective parties: the State believes if QMRPs are not found to be "management" employes, their present placement of QMRPs in the professional Fiscal and Staff Services unit is most appropriate; District 1199W/Professionals for Quality Health Care advances the professional Patient Care unit as the most appropriate for QMRP placement; District Council 24 of the Wisconsin State Employees Union urges the professional Social Services unit is most suitable for the QMRPs.

The majority, while acknowledging the placement issue ". . . produces a close question as to whether the QMRPs are most appropriately placed (in) the Social Services or Patient Care unit," opts for Patient Care. Although this choice is not irrational, its heavy reliance on the past education and back-grounds of a small majority (23 out of 40) of QMRPs, is not persuasive to me. It would be as logical to assert that since education is the professional background most often brought to the state legislature, all state legislators should be classified as "teachers." But, just as the roles of state legislators are expected to transcend whatever their respective professional backgrounds may have been, so it is that the roles of QMRPs have expanded well beyond the "hands on" care activity still required of PPCU employes.

Neither am I persuaded by the remaining contentions made by the majority in support of its determination. None of them, for instance, satisfactorily address the undisputed "case manager" responsibilities of the QMRP positions -- responsibilities long associated with social workers. 6/ While the majority points to PPCU persons who also appear to have "case manager" responsibilities, those instances do not appear to represent a common pattern.

The majority additionally claims ". . .the 'case manager' role performed by Social Service employes naturally focuses more on delivery of social services rather than patient care which is the QMRP's focus." But this argument is not responsive; it merely begs the question. The ultimate issue of this case is whether "patient care" is the focus of QMRPs. That issue cannot be rationally resolved by simply asserting it is so. This is particularly true where, as here, "patient care" has been traditionally associated with a "hands on" approach: while some QMRPs may occasionally provide "hands on" patient care on a volunteer basis, it is clear they are not regarded as "hands on" people. 7/ Thus, the best that can be said of the majority's argument in this instance is that it represents its subjective preference. At worst, it reflects the majority's inability to distinguish between "plans of care" (recited in the QMRP position description) and "patient care."

Nor do the arguments marshalled by the majority adequately address the "conflict of interest" issue raised by both the State and WSEU. The majority merely notes that ". . . Patient Care employes (nurses) performed the QMRP function in the past and there is no evidence that they did not effectively carry out their oversight function over fellow Patient Care employes." From this the majority concludes, "(w)e see no reason to believe that such a conflict can emerge."

It is true that some nurses (and for that matter, by inference, social service employes) have served on what were once called transdisciplinary or interdisciplinary teams. Members of these teams were the precursors to the present QMRPs. That there is no evidence that nurses serving as QMRPs experienced any conflicts of interest with PPCU employes is hardly remarkable; QMRPs, since their creation in 1988, have been in a different bargaining unit than PPCU employes, thus offering no opportunity for conflicts on interest to arise in the recent past. As for pre-1988 experience with transdisciplinary or

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6/ Tr. 62.

7/ Tr. 18.

interdisciplinary teams, there is no record indication that any scrutiny of them as to conflicts of interest was attempted by any of the parties. Indeed, to have attempted such a survey would have been both difficult and expensive. On this state of the record to assert, categorically, the absence of any reason to believe that such a conflict could emerge, as does the majority, is to substitute wishful thinking for logical inference.

For at least these reasons, 8/ were our options limited to QMRP placement in the professional Patient Care unit or that of professional Social Services, I would select the latter. While that matching would not create a "perfect fit," on balance I believe it less frictional than the alternative preferred by the majority.

* * *

There is, however, a third alternative to which the majority gives little consideration. It is that of the Fiscal and Staff Services unit -- an alternative which, in my view, suffers from less infirmities than those endured by either the PPCU or professional Social Services unit.

The F&SS unit is broadly based, and currently includes a variety of professional positions, several of which do not appear to involve providing ". . . administrative support and technical expertise for various state functions," the views of the majority notwithstanding. 9/

As classification expert Glen Blahnik testified, the F&SS unit ". . . is probably the broadest grouping of classifications in any one statutorily identified bargaining unit." 10/ According to Blahnik, unit position exhibit great diversity. "They could be lead workers, they could be group workers, they could be professionals working in an individual capacity." 11/ Significantly, included in this unit are class specifications for what an earlier Commission characterized as "broad general subject areas", such as the planning analyst, management information specialist, and educational service assistant series. 12/

8/ Neither should the striking parallel between the "patient advocate" role expected of QMRP's and the traditional "client advocate" role expected of social workers be ignored.

9/ The quoted material is from the majority's opinion which cites Dept. of Administration (Fiscal & Support Staff), Dec. No. 15836 (WERC, 9/77) as authority for such view. The majority's reliance on this case for the point in question seems misplaced and represents, at least, an interpretive expansion of the determinations made in that case.

Ironically, however, the case does offer a convincing basis to conclude that there exists a strong community of interests between the F&SS unit and the QMRPs, as is more fully developed, above.

10/ Tr. 179.

11/ Tr. 178.

12/ Dept. of Administration (Fiscal & Staff Services), Dec. No. 15836 (WERC, 9/77).

Community services specialists, training officers, and hospital administration consultants -- all currently placed in the F&SS unit -- would appear by their titles to be in the same category.

Most persuasive to me is the "community of interest" which appears to exist between the F&SS unit and the QMRPs. Unlike the more narrowly banded relationships between QMRPs and either the PPCU or professional Social Services unit, the "community of interest" shared by the QMRPs with the F&SS unit is not chained to a specific discipline. It is, instead, a shared professional duality of independent, objective oversight in a multi-disciplinary setting.

Instructive to note are the findings of the earlier Commission referred to above (which included a member of the present majority) in placing what is now called the program and planning analysts in the F&SS group:

> "The planning analysts, however, unlike research analysts, then analyze that raw data and make specific recommendations for proposed courses of action as well as supplying rationale in support thereof." 13/

This broad capacity of analysis and specific recommendation (with supporting recommendation) is another indicator of the strong community of interest between the Fiscal and Staff Services unit and the QMRPs.

To attempt to differentiate between the "patient advocate" role expected of QMRPs and the role of an F&SS employe who is expected to ". . . analyze that raw data and make specific recommendations for proposed courses of action as well as supplying rationale in support thereof" strikes me as creating a difference without a distinction. This, in effect, is what the majority does when it cursorily dismisses the F&SS unit as a poor third.

To me, however, the case oversight or even "patient advocacy" described by the majority as required of the QMRPs is not something normally or routinely required of Patient Care personnel. It does, however, have striking similarities to elements of position descriptions for positions this Commission has already included in the F&SS unit. The majority elects not to deal with this, relying, instead, on an over-generalized characterization of F&SS positions as merely providing "technical and administrative support." Some do. But, as noted above, a fair number incorporate the same analytical and advocacy skills required of QMRPs.

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Thus, I dissent from the majority's placement of the QMRPs in the Patient Care unit.

Dated at Madison, Wisconsin this 24th day of January, 1991.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By ______________________________
A. Henry Hempe, Chairman

13/ Supra. That Commission went on to specifically note: "The record also establishes that management information specialists and educational service assistants are in the Fiscal and Staff Services bargaining unit, and that they perform Supportive functions which are similar to those functions performed by the planning analyst."