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"*The JCAP constitutes the culmination of months of intense discussion, review and evaluations between the United States Department of Justice, the Commonwealth Department of Health, and the Court Monitor…* ***the Court now expects the Commonwealth to fully and readily comply with the JCAP****".*

- Hon. Gustavo A. Gelpí
  Order Adopting the Joint Compliance Action Plan. August 19, 2011

I. Introduction

The Federal Monitor's Office hereby presents its third Six-Month Status Report regarding the Commonwealth of Puerto Rico's ("Commonwealth") compliance with the mandates set forth in the Joint Compliance Action Plan ("JCAP") since the benchmarks stipulated by the Parties in the present case were adopted (and fourth in total). The present report includes comments and contributions by the parties in compliance with the directives of the Court. The method of illustrating our assessment for the present Report consists of cross referencing the benchmarks by their corresponding number and applying specific colors to represent the level of compliance the JCC opines that has been reached to date by the Commonwealth.

Although the JCC considers that the Commonwealth has realized some progress in several areas that we identify in the present Report such as the preparation of mortality reports, the implementation of a crisis hotline, and the fact that two (2) participants are transitioning into independent living, there are still vast reforms to implement and numerous challenges to overcome before the Commonwealth begins to approach sustainable compliance. It is imperative to mention that, while aspiring to reach full compliance with the JCAP within a reasonable time-frame, everyone involved in the above goal must have extraordinary sensitivity to the fact that participants will not get another opportunity to relive their lives.

Considering that the present case is approximately twenty (20) years old, the JCC is deeply concerned with the pace of progress as it pertains to protecting participants rights and working well as the aspiration to give every participant in the program a meaningful life. Hence, in this Report the JCC will propose to the Commonwealth remedial recommendations to advance its progress in implementing the JCAP per each benchmark assessment with the exception of those that are deemed in compliance[1].

[1] Nevertheless, the JCC will be evaluating in each biannual report whether or not each benchmark that reaches compliance is sustainable.

The present Report was prepared relying on specific compliance data furnished to the JCC covering the period between March 31, 2019 to July 31, 2019[2]. The present Report also includes recent findings with respect to certain areas that the JCC deems of paramount importance to address, as well as others that are not expressly a part of the JCAP, but have been reached by consent of the Parties with the endorsement of the JCC and the approval of the Court. The aforementioned mandates are fundamental in order to assure that the participants of the DSPDI program receive all of the services and attention they require as mandated by the JCAP. The Federal Monitor's Office would like to recognize that these additional efforts are taking place in great part due to the USDOJ's recommendation that the JCC take a more active role and serving as a "guiding hand" to the Commonwealth of Puerto Rico in reaching consistent and sustainable progress as it relates to the JCAP, which will hence ultimately lead to full compliance in all mandated areas. (See Docket No. 2285). This also lead to the Parties agreeing to a revised budget which enabled the JCC to retain additional experts and conduct further actions for the benefit of both the participants and the Division of Services for People with Intellectual Disabilities (DSPDI). (See Docket No. 2454).

As of today's date, the JCAP has been in effect for approximately eight (8) years, and although much progress has been made, there is still a significant amount of work to be done in order for the Commonwealth to reach full and sustainable compliance. As it will be demonstrated in detail in the present Report, the Commonwealth's level of compliance with the Benchmarks has increased from a 19.6% to 24% [3], which although favorable, is taking excessively long, as the original intent of the Court was to conclude the implementation of the JCAP within three (3) years (*Order Adopting Joint Compliance Action Plan*. Docket No. 1185).

II. General Overview

Budget Concerns

It is imperative to mention that for more than a decade and until very recently, Commonwealth has repeatedly used its precarious fiscal situation to justify low compliance levels in certain areas of the JCAP. However, even though the Federal Monitor's Office agrees that the island's fiscal situation is certainly a dire one, the Court has been adopting measures to ensure that the services that the participants receive are not curtailed, interrupted or limited in any way. This has been the case since the adoption of the JCAP in the year 2011 and it is still the case as of

[2] The Federal Monitor's Office is only including information up to this date due to the fact that there is no uniformity regarding the dates of the information furnished by Commonwealth. The JCC recognizes that between the aforementioned date and the filing of the present Report, the Commonwealth would have furnished further information, which will be considered for the March 2020 Six-month Report.

[3] The present figure is a general assessment, not a weighted statistical evaluation.

today's date. (See Section II-C of the JCAP. Docket No. 1185, at pages 6-7; See also Docket Nos. 1368, 1652, 2032, and 2562).

As stated in numerous transition orders issued by the Court as well as in the JCAP, "No action will be taken that places in jeopardy the constitutional rights of program participants", "the services to the participants shall remain uninterrupted unless otherwise ordered" (See Section II-C of the JCAP. Docket No. 1185, at pages 5 and 7 (Citing Docket No. 1010). Notwithstanding the above, a recent investigation and analysis conducted by the JCC has shown that since the fiscal year 2015-2016[4], the Commonwealth has not used over **twenty (20) million dollars** of the allocated and ordered budget for DSPDI, (See Docket No. 2562).

The above situation as well as the need to replace depleted staff as acknowledged by the DSPDI in its capacity plan is alarming for the Federal Monitor's Office for a number of reasons, but mainly because it has the effect of curtailing or limiting the essential services the participants need as well as perpetuating levels of service that the JCC deems unsatisfactory to the well-being of all participants, particularly when compared to the types and quality of services that the Commonwealth is required by law to furnish.

Furthermore, as will be illustrated in the present Report, the above situation has impeded, in part, the Commonwealth from improving its compliance level with the benchmarks and the JCAP. For the JCC it is simply unacceptable that the Commonwealth has been justifying the low compliance levels to its fiscal situation, while at the same time, it has been directly defying the orders of the Court[5] that were issued to protect the resources that the Department of Health and the DSPDI need to continue to improve the types of services that the JCAP contemplates for all participants. (See Section II-C of the JCAP. Docket No. 1185, at pages 6-7; See also Docket Nos. 1368, 1652, 2032, and 2562). In submitting to the JCAP, the Commonwealth represented to the United States and the Court that the aforementioned situation was never going to happen and if it were going to happen, they were going to notify the Court. However, if not for the JCC's investigations into the use of existing resources by the DSPDI, the Court, the US and our office would still be in the dark.

Re-evaluation of Participants

[5] The Commonwealth has a continued legal obligation to properly inform the USDOJ, the JCC and especially the Court of any budgetary cuts and loss of human resources that may affect or put at risk the services that participants receive.

DSPDI has identified over eleven (11) participants which it deems to no longer have ID/DD. As a result of the above information, the JCC sought the assistance of the Court in order to have the above-mentioned participants re-evaluated by an independent expert to provide an opinion as to the ID/DD diagnostic (See Docket No. 2482; and 2499). Consequently, the Court appointed as an expert Dr. María Margarida Juliá, with the consent of the Parties, who at the moment has evaluated two (2) participants and concluded that they in fact have ID/DD, and has identified other relevant and important flaws in the scientific methodology that was being used by the DSPD to evaluate said participants.[6]

This matter is of extreme importance due to the fact that a situation could occur in which a participant with ID/DD will cease to receive proper and needed services, while on the other hand, the Program can also confront the dichotomy that a person with no ID/DD would be receiving services which are not required to treat their condition. Therefore, the JCC is of the opinion that the aforementioned re-evaluations must keep taking place when warranted, as it is currently being done. Every participant's well-being is important and at a minimum, every participant is entitled to a proper ID/DD diagnosis.

People with ID/DD Under the Local Judicial Jurisdiction

There are currently a number of people with ID/DD that have not been adequately diagnosed or treated, and end up in the Commonwealth's Judicial Branch for actions that are deemed infractions or violations to the local Penal Code. This could be a matter of life and death in certain cases as these persons are often incarcerated along with the general population of inmates, some for alleged sexual offenses [7], people with DD should not even be subject to the judicial process. Criminal prosecution should be a measure of last resort. The JCC will continue to work with the DSPDI to find a better method to address the above problem. Moreover, the JCC has agreed to contribute to the DSPDI's efforts by providing orientation on the ID/DD community to members of the judiciary, as well as to prosecutors from the Department of Justice.

If it were not for the timely intervention of the Federal Monitor's Office, two (2) participants in particular (INR #156 and LML #505) would most likely not be alive today due to the serious situations they were facing while incarcerated with the general population of

[6] The JCC anticipates that the methodology that the DSPDI uses to re-diagnose participants will have to be modified to satisfy the current best medical practices. The JCC is committed to assisting the Commonwealth in said endeavor through the services of Dr. Margarida Juliá..

[7] Recently, several reports in the media have addressed the alarming rise in the death of inmates within the Commonwealth's correctional system.

inmates, where they were subjected to physical and even sexual abuse. This is not the first time the JCC has had to intervene with regard to the safety of an incarcerated participant[8].

The Federal Monitor's Office deems it of paramount importance to establish effective collaborative mechanisms with the judicial branch in order to address these types of situations and the proper handling of criminal cases that people with ID/DD could be facing. Although, numerous meetings have been held in the past with members of the judicial branch, as well as visits by members of the JCC to the court hearings and correctional facilities related to the above-mentioned cases, a comprehensive action plan should be adopted by the Commonwealth in order to effectively address these life and death situations.

Community Placement

The Federal Monitor's Office is deeply concerned that the Commonwealth is still using institutions for the placement of new participants. It is the JCC's opinion that said action could very well be in direct violation of the principles set forth by the Supreme Court in Olmstead v. L.C., 527 U.S. 581 (1999). Incredibly enough, there has been an increase in the number of participants that are currently residing in institutions instead of in community home settings. There is still no individualized transition plans in place to effectively address the participants' transition into community homes as mandated by the JCAP. (See Section II—1 of the JCAP. Docket No. 1185, at pages 7-8).

The practice of placing new participants in institutions, in all likelihood violates these citizens' rights. Therefore, the JCC recommends this practice should cease and that the Commonwealth should provide community alternatives to new participants with DD. It is one thing to have institutionalized participants starting a belated transition process to community homes according to Section III-1 of the JCAP (Docket No.1185, at pages 7-8), and another thing is to refer new participants to institutions that are in the process of downsizing for precisely violating participants' rights.

A Growing ID/DD Population

In regards to the ID/DD population in the island, the JCC is aware that there is a growing population that has been identified by the Department of Education in the special education students list furnished to our office as part of a collaborative agreement between the

[8] A recent hearing regarding participant (LML #505) revealed that his brief stay in a correctional facility exposed him to significant and traumatic physical and mental harm. The Commonwealth court ordered his transfer out of the correctional facility and emphasized that there are better ways of dealing with these problems, among other important utterances.

Department of Education and the Department of Health[9]. According to the aforementioned list, there is a total of one hundred seventy five thousand (175,000) special needs students, most of whom could eventually require services from the DSPDI[10].

Furthermore, the JCC is also concerned by the fact that there is a growing ID/DD population in the island that is not being accounted for. The JCC, through numerous field visits throughout the Island, clearly perceived an increase in the ID/DD population that is seeking services from the DSPDI and are currently held in a waiting list in some cases or are not being considered at all in others. Some underserved ID/DD participants may end up in psychiatric hospitals, DSPDI custody and at times, in jail or prison through local judicial orders.

The Program is simply not prepared to provide adequate services to the incoming population with ID/DD. The JCC is of the opinion that turning our backs on these individuals is simply not an option as long as the Court has jurisdiction over the implementation of the JCAP.

Provider Capacity Expansion and Rate Assessment Study

The JCC expects that a competent, experienced and independent company will properly evaluate the costs of all relevant services offered by the DSPDI, including evaluating all costs per participants pursuant to their individualized needs and levels of physical and mental health care. Said study will greatly benefit the DSPDI and all participants. Moreover, it should ultimately enable the Commonwealth to provide additional incentives for the opening of new community homes, identify additional resources for the Centers of Transitional Services (CTS), and improve the use of economic resources in an equitable and more effective manner[11].

The opinion that the pending rate assessment study should help the Commonwealth increase its current compliance levels in important areas[12]. Currently, numerous community homes shelter six (6) participants, even though it is generally understood that there should be no

[9] A similar collaborative agreement was entered into with the Department of Family Affairs, but they have not furnished the necessary information that the JCC Office needs and has requested regarding people with ID/DD under their care. The JCC reminds the Commonwealth and DSPDI that it needs to request from the Department of Education an overdue updated students list.

[10] We cannot determine the exact amount of students that have ID/DD from this list.

[11] Presently, the Department of Housing and Urban Development (HUD) has disclosed that 112 millions are available until February 10, 2020 to built community homes; that information was shared with DSPDI during the last monthly meeting with the JCC.

[12] **The JCC expects the Commonwealth to enter into a rate assessment agreement with Burns and Associates by October 31, 2019. The JCC expects the Commonwealth to comply with the deadlines accorded in the Joint Action Plan (JAP).**

more than four (4) people in one community home[13]. In the past, this practice has been evidently tolerated by the USDOJ and the Court due to the fiscal constraints the Commonwealth has been facing. The time for reassessing the above standard should be on the horizon. The Commonwealth should move promptly to adopt the four (4) participant per community home standard. The pending rate assessment study will shed light on how the Commonwealth can better utilize scarce resources to open new community homes to properly place all participants.

An area that is worsening is the payment to the providers; the JCC office spends too much time (almost on a daily basis) addressing the matter with the providers and the DSPDI. The JCC expects that the DSPDI and the Secretary's Office establish a mechanism where this and other important matters like the Permits for new Homes could be resolved permanently.

Integrated Employment and Day Activities

Pertaining to Integrated Employment and Day Activities, there are no significant changes from the JCC's March Status Report to the present, except that five (5) additional participants are currently working, for a total of nineteen (19) employed participants. This is one of the most important areas of the JCAP given its direct effect over the participants' ability to integrate in the community and to transition into independent living. However, it is still one of the areas representing the least amount of improvement over the years. This matter has become more relevant recently due to the fact that for the first time in twenty (20) years, we have two (2) participants transitioning into independent living.[14]

The following is a table that illustrates the number of participants per CTS and days the attend to receive services:

CTS	Participants	Days participants attend
Bayamon	84	2 per week (+ alt Fridays)
Vega Baja	114	1 per week (+ 1 Friday a month)
Ponce	55	4 per week (+ alt Fridays)
Aibonito	27	5 per week

[13] **The JCC is deeply troubled by the fact that DSPDI has 15 community homes (39.5% of all community homes) with over 6 participants. Some community homes have as many as 9. The above egregious housing practice must be orderly terminated.**

[14] The JCCexpects that more participants will start to transition towards independent living before the filing of our next report.

Rio Grande	49	3 per week (+ alt Fridays)
Cayey	39	3 per week (+ alt Fridays)
Aguadilla	104	3 per week (+ alt Fridays)

Furthermore, the JCC finds that the Commonwealth has failed to identify other alternatives in this regard, such as voluntary work and community activities, which although not remunerated, will enable the participants to develop important skills and relationships that will ultimately increase the participants' chances to obtain a remunerated job. (See Section III—3 of the JCAP. Docket No. 1185, at pages 8-10).

The CTSs should offer services to participants five (5) days a week in order to meet participants's individualized needs per the JCAP[15]. To this end, the Commonwealth should begin 2020 with the objective of creating five (5) capacity building days (eight (8) hours a day) in every CTS for every participant. The JCC expects a proactive management approach by the DSPDI.

Safety and Restraint Issues

Proper implementation of the TherapServices® (Therap) platform is fundamental to an effective method for incident reporting and follow up, health monitoring, as well as updating progress reports by the CTS, the Clinic Specialized in Evaluation and Consulting ("CEEC") and interdisciplinary teams, among others[16]. According to the Therap Implementation Plan, out of fifty-seven (57) group and community homes, only thirty-one (31) use the Therap platform. Moreover, there are currently eight hundred twenty-four (824) users and only one (1) person to provide training on how the platform works. Furthermore, the JCC finds that the Therap platform still has outdated information regarding medication, and diagnostics, among other basic information in participants' profiles. Furthermore, Dr. Reynaldo Rodríguez Llauger, chairman of the Mortality Review Committee has expressed serious concerns regarding the information currently available in the platform. Dr. Rodríguez describes the above troublesome situation as a "garbage in, garbage out" dilemma which for obvious reasons must be remediated expeditiously.

Health Care and Mental Care

[15] Currently, there is no uniformity between the CTS regarding the number of days that participants are receiving services.

[16] Given the contractual relationship that exists with TherapServices, the Commonwealth had the obligation to establish and implement a proper system that would resolve any technical issues once and for all; this should have been implemented by 2012. (See Section IV-B of the JCAP. Docket No. 1185, at page 11).

As for the Health Care and Mental Health section of the JCAP, there is substantial fundamental information missing in order to properly evaluate the Commonwealth's compliance level. First of all, there are no official reports from the CEEC's physician, psychiatrist and nutritionist, therefore there is no official information regarding: action plans for the year 2019; number of participants that were evaluated by the aforementioned professionals; number of consultations and clinical interventions offered to the participants; crisis hotline number of calls and interventions (although the hot line has been established, it is still deficient regarding information on matters that may trigger emergency attention); and the use of the "*GeneSight test*"[17] and how the results are being used.

As for the matters pertaining to psychiatric care, including polypharmacy and the prescription of multiple psychotropic medications to participants, the Federal Monitor's Office is currently retaining the services of Dr. Roberto Blanco, a renowned expert on the subject matter, to evaluate the aforementioned use in in accordance with the mandates of the JCAP. (See Section III—5 (K-2) of the JCAP. Docket No. 1185, at page 14). If in the process of conducting field investigations and on-sight inspections of community homes, CTS and other sites with Dr. Blanco, the JCC is concerned that the psychotropic medications that are being prescribed and administered impair the well-being, health and potential improvement of skills that numerous participants need to legitimately aspire towards independent living and meaningful life.

In regards to the required mortality reports, the Federal Monitor's Office recognizes that there has been some note-worthy progress under the direction of Dr. Reynaldo Rodríguez Llauger. Nevertheless, there is still significant work to be done in order to reach full compliance with the JCAP. For instance, the mortality reports of deceased participants are still taking longer than the thirty (30) day time-frame mandated by the JCAP (See Section III—5 (N-5) of the JCAP. Docket No. 1185, at page 16); and the written recommendations for remedial actions with regard to individual and systemic issues related to the deaths are not being furnished pursuant to Section III—5 (N-6) of the JCAP (Docket No. 1185, at page 16); among others. However, the most worrisome aspect for the JCC regarding the mortality reports, is the fact that serious problems are being identified in regards to preventable causes of death and other deficient practices that are not being properly addressed at an individual or systemic level.

Although the JCC commends the progress made so far in this area and acknowledges that we expect more progress in the future, we are compelled to include in this Report the specific areas that still need attention and improvement in order to reach full compliance with the JCAP.

[17] The GeneSight test is a pharmacogenomic test that analyzes how a person's DNA may affect its response to depression medications.

System Wide Reforms

Finally, in regard to the System Wide Reforms section of the JCAP, the Federal Monitor's Office finds that there are certain areas that are still under partial compliance, such as:

- Full implementation of the Therap Services platform;
- Implementation of a quality assurance program to track, analyze, and ensure participant safety, welfare, health care, mental health care issues and outcomes; and
- A respite program for parents and individuals that have ID/DD participants under their direct care.

Proper emergency plans and drills for earthquakes and hurricanes have still not been effectively implemented, especially at night. While preparing the present Report, a seismic tremor of a six point one (6.1) magnitude in the Richter Scale took place just the night before a tropical storm was expected to land on the island. Adequate emergency plans and drills must be implemented without any further delay whatsoever. The JCC raises the above matter in almost every monthly meeting and on most field visits with both the providers as well as with professionals and staff members of the CTS. The Commonwealth can expect full cooperation from the JCC in all related matters but should not expect further patience for inaction, as lack of proper preparation for earthquakes puts at risk the safety of all participants and can instantly become a matter of life and death.

In summary, the Federal Monitor's Office is optimistic that the present Report will not only serve as a valuable instrument to provide a comprehensive and empirical analysis of the current compliance landscape, but also as an indispensable working instrument moving forward into helping the Commonwealth reach full compliance with the specific benchmarks and the JCAP. The JCC is confident that with the additional help that will be furnished to the DSPDI; with the proper discipline that is mandated in the JCAP (See Section I of the JCAP. Docket No. 1185, at page 1),; and with a reinstated DSPDI budget (which entails adherence to Court orders), providing a meaningful life to all participants and protecting their constitutional and civil rights is a mandate that can and must be fulfilled within modified deadlines that should be defined by the Court. In the next section of the present Report, the JCC Office will address each benchmark with particularity and suggested remedial actions.

III. Ratings of Compliance with Specific Provisions of the Agreement

The following section presents the Commonwealth's Compliance with respect to the JCAP.

A. Community Placement from Institutions

As expressed in the introduction, the Federal Monitor's Office is very concerned with various matters pertaining to the Commonwealth's compliance with the provisions related to Community Placement from Institutions. The numbers presented in the table below represent a regression from our previous Report as it pertains to compliance with this particular area.

Table 1: Distribution of participants by institution:

	March 2019	April 2019	Change In Participants
Fundación Modesto Gotay	44	47	+3
Instituto Psicopedagógico	33	39	+6
Shalom	46	55	+9
Total	123	141	+18

As of April, the DSPDI has a total of eighteen plus (18+) additional participants living in institutions, which constitutes a thirteen percent (13%) increase from our previous Report. According to the above numbers, twenty two percent (22%) of the population served by the DSPDI is still placed in institutions.

The JCC notes that the above data should have been modified by the Commonwealth in May 2019, due to the opening of Modesto Gotay Community Home where six (6) participants from Modesto Gotay Foundation were placed. It is important to note that the *Psicopedagógico IV* Community Home mentioned in the March 2019 Report is still pending to be opened. As previously mentioned, it is evident that the institutions continue to be used by the DSPDI as viable options for the placement of participants. The JCC is of the opinion that said practice should cease and that community alternatives to institutionalization should be developed.

DSPDI has begun some positive initiaves towards orienting parents and relatives of participants in institutions about the benefits of transferring said participants to community homes. regard. These include facilitating visits to community homes, as well as educating institutional families. Although important, said efforts, thus far are not enough to obtain significant results as it pertains to compliance standards. It is imperative to note that those family members, as a matter of principle, do not oppose to the relocation of their relatives with ID/DD to community homes. However, they oppose the particular placement option currently being offered by the DSPDI, mainly due to the great geographical distance between the proposed community home and their residences. Lack of close proximity would limit the parents from visiting the participants on a regular or consistent basis. The present matter can be resolved by providing these relatives viable community home options for placement. This will greatly improve

the integration process of said participants and will improve the Commonwealth's compliance.

Table 2: Parents who did not accept the relocation of participants

Institution	Parents oriented and have not accepted placement	Reasons
FMG	2	Location of the proposed home
IPPR	6	Location of homes / Quality of services at the CTS
Shalom	1	Location of homes / Quality of services at the CTS

The main reasons for the relatives' opposition to community placement are: (1) the distance of the facilities proposed by the DSPDI; and (2) the quality of the services offered by the CTS. The three (3) existing institutions are located in the metropolitan area, and the new proposed homes, in their majority, are located in remote areas of the Island.

In order to reach the present goal, an individualized transition plan is needed for each participant. (See Section III, 1-A of the JCAP. Docket No. 1185, at page 7). The challenges faced and the strategies to overcome the same should be itemized in the plans. DSPDI should assume a more active role in analyzing and addressing the concerns of participant's parents and relatives. It is important to note that transitional plans are developed only for those participants who are about to be placed in community homes, but not for the total population currently living in institutions as is required in the JCAP. (See Section III, 1-A of the JCAP. Docket No. 1185, at page 7).

Feasible geographical areas for community placement should be explored and discussed with the participants' relatives and at times with parent associations as part of the orientation process required by the JCAP. (See Section III, 1-B of the JCAP. Docket No. 1185, at page 7). DSPDI should obtain a real and accurate information with regard to the efforts that are being taken to open new homes, as well as the availability of essential services for the participants. This information will allow DSPDI to reevaluate any existing plans for the opening of new homes.

It is imperative that the existing plans for the opening of new homes by the DSPDI should be tempered to address the above concerns in order to furnish feasible placement options for the participants still residing in institutions. Unless the Commonwealth understands the importance of the correlation between family support and the need to furnish essential services, opposition and resistance to participants' placement will continue.

The assertive and open communication between the DSPDI and the participants' relatives who oppose relocation to community homes should be ongoing. DSPDI should discuss real

options that would enable these relatives to find a solution to their concerns. In order to achieve this goal, the tabulation and analysis of the concerns set forth by the participants' relatives should be integrated in the remedial plans in order to address the same and make them feasible. DSPDI should continue its efforts to educate through trainings, lectures or workshops where doubts can be clarified and further information can be provided, especially as DSPDI's action plans and service offerings develop and mature.

It is also important to mention, that upon comparing the March 2019 JCC Report and the data furnished by the DSPDI on April 23, 2019, the JCC finds that there is a reduction of only one (1) participant in regard to the total population served by the DSPDI. From a total of six hundred forty-six (646) participants in March 2019, to six hundred forty-five (645) as of April 2019. A more thorough investigation into existing program waiting list should be expected by the DSPDI from the JCC.

BENCHMARKS: 4-9 (See Attachment 1 for the benchmarks related to each area on the report)

B. Provider Capacity Expansion in the Community

The JCC finds that there is much work to be done in this area of the JCAP. As of today's date, the majority of Community Homes shelter six (6) participants not four per home (please see footnote 13), as generally recognized as better; substitute homes should have no more than two individuals with disabilities in residence. As mentioned in the introduction, the JCC is of the opinion that the pending Rate Assessment Study and the opening of new community and substitute homes, should help the Commonwealth reduce the current number of participants currently living in community homes (the aspiration should be of two (2) participants per substitute home).

BENCHMARKS: 13-16

C. Integrated Employment and Day Activities

In accordance with the data provided by the DSPDI, the following changes are highlighted and identified in the following table:

Table 1: Comparison of the *Area of Services on Vocational Rehabilitation Services* (ASCERV) data between February 2019 and July 2019.

	February 2019	July 2019

Employed participants	14	19
Participants able to work	14	9
Participants in vocational workshops	46	56
Self-employed	20	16
Referrals to the Voc. Rehabilitation Adm.	8	7
Participants unable to work	515	514

From the data furnished by the DSPDI, it stands out that from a total of six hundred forty-five (645) participants, only nineteen (19) participants are currently working (this equals three percent (3%) of the population served). Eight (8) participants (equal to one-point four percent (1.4%), worked twenty (20) hours or more each week, and ten (10) participants (equal to one-point five percent (1.5%), worked from six (6) to fifteen (15) hours each week. This last data shows that many of the employed participants are under employed. Additionally, one (1) participant is in a work experience which consists of a total of one hundred (100) hours, but a long-term employment is not yet guaranteed.

The present population served by the DSPDI is six hundred forty-five (645) persons, the Commonwealth claims that, (514) participants are unable to work. We expect that CORE will help determine whether or not this figure is valid. Regardless, (103) participants, may have some potential for employment, however at present they remain unemployed.

The recommendations itemized in previous JCC reports are still relevant. These include: (1) the use of the adequate vocational mechanisms; (2) individualized employment promotional plans; and (3) collaboration with agencies and organizations with experience and resources that could increase the probability of obtaining employment.

Likewise, in general terms, the same observations previously highlighted by the JCC in previous reports still persist, such as:

1. <u>The need for additional personnel in ASCERV:</u> The lack of key personnel in this area limits the availability of services required to achieve desired employment goals or greater independent living by the participants. As of today's date, there is only one professional at Vocational Rehabilitation Counseling (CRV) to provide services to the entire population of participants in the DSPDI. This is not acceptable to the JCC. Proper use of available resources can improve the quality of services that participants require.;

2. ASCERV employees: There are (17) employees who report to ASCERV. This represents an increase of two (2) individuals. Although said increase is indeed positive, the number of employees is still deficient as it pertains to the needs identified in the CTS census.
3. Professional training: According to the information furnished by the DSPDI, there has been no formal or specialized training in the last twelve (12) years. The above situation places the CRV personnel at a disadvantage by not having access to the necessary tools and strategies that are required to properly prepare participants for the current labor market demands. Consequently, the probability that a participant may aspire and obtain a job, will be significantly diminished.
4. Lack of Scientifically Validated Tools: There is still a lack of scientifically validated tools to support the work of the CVR and its work group regarding the identification of vocational rehabilitation services needed to allow participants to find employment consistent with their strengths, resources, priorities, abilities, interests, residual functional capacity, and informed selection. Due to the lack of such tools, it is impossible to know with certainty the real number of participants that would benefit from the strengthening of the specific areas that could be identified with the adequate mechanisms and inventories. The above increases the probability of participants having success in the labor market, but unfortunately, they are unavailable in the DSPDI program.
5. Lack of Collaborative Agreements: The JCC is aware of the existence of an infrastructure in other agencies (for example, through the Workforce Innovation and Opportunity Act (WIOA), that would increase the possibility of participants obtaining employment. However, we have not identified any documents that could lead us to conclude that there is a process of formal or integrated collaboration between DSPDI and these other agencies and divisions. An effective and coherent collaboration agreement would allow the DSPDI to work with other employment/vocational agencies to maximize fiscal and human resources, thus increasing the probability of favorable employment results.
6. Subemployment[18]: According to the available data, ten (10) out of nineteen (19) or fifty three percent (53%) of the participants worked from six (6) to fifteen (15) hours a week. Some still indicate that they are not working as much as they would like, or that they are able to, due to lack of opportunities or employer issues. The above information was validated by the ASCERV personnel.

[18] The Office of the JCC has received recent information that some participants may be proximately facing a reduction in their working hours. The JCC will be working closely with the Commonwealth to identify effective means to address the subemployment problem.

The JCC recognizes that the DSPDI cannot guarantee optimum employment for all participants. However, we have not identified efforts or concrete measures to prevent the subemployment of said participants. As previously mentioned, some steps that would help in this process include the use of vocational mechanisms, individualized employment promotional plans, collaboration with agencies or organizations with experience and resources that would increase the probability of employability. As of today's date, once again, there is no evidence that any of the above steps have been taken by the DSPDI.

By November 2019, the DSPDI expects to receive the results of the *Puente Project,* a collaboration agreement between the University of Puerto Rico and the Department of Health. The aforementioned proposal is titled *Development of the Vocational Rehabilitation Counseling Section of the Services to Persons with Intellectual Disability Division of the Department of Health*. The JCC will analyze the organizational structure of the Vocational Rehabilitation Counseling Section of the DSPDI; conduct an analysis of the functions and duties of the personnel attached to the ASCERV area; and carry out a needs assessment of the services directed to independent living, social-community reintegration, work and employment. The Commonwealth claims that significant changes have not yet been madein the ASCERV structure because the results of the *Puente Project* are not yet available.

BENCHMARKS: 17-39

D. Safety and Restraint Issues

In this area the objective is to guarantee the safety, wellbeing and protection of all participants, especially those who are vulnerable and at high risk.

Since 2017, the DSPDI has started to implement the *Therap Service*® electronic platform, which offers the following services: incident reporting; health monitoring; progress notes of CTS and CEEC interdisciplinary teams; documentation of work shifts in the homes (T-Log); as well as matters pertaining to billing, employment, and finances.

In accordance with the "Therap Services Implementation Plan" report, out of fifty-seven (57) homes (substitute and community), only thirty-one (31) homes currently use the Therap Services platform, which has eight hundred twenty four (824) users and only one (1) coach to provide training on how to use the platform. Furthermore, there are still twenty-six (26) homes and three (3) institutions which have not yet implemented the Therap platform. DSPDI has spent three (3) years in the process of implementing the Therap platform and there are still numerous challenges to overcome in order to achieve full implementation. Due to the above situation, compliance dates were established by the Parties in the Joint Action Plan to measure the implementation progress since it is still in developmental stages.

The JCC continues to find that important information has not been updated in the participant's profiles such as medication, diagnosis, weight, etc. This discrepancy in documented information is validated by reviewing the clinical records during our visits to homes, CTS and institutions. Furthermore, Dr. Reynaldo Rodríguez-Llaguer (chairman of the Mortality Committee) indicates that he does not use the Therap Services platform for his mortality reports because he recognizes that the platform is in the implementation process, and for such reason the data is not up-to-date, and is not a reliable source of information. The JCC deems it necessary to contract trained personnel to update the information on the Therap platform in order for it to be a reliable source of data for use in the analysis of incidents and its multiple functions.

The JCC Office, in its interest and efforts to assist the Commonwealth with said plan, has retained the services of a court approved external consultant, Mr. Scott Cragg, to support and assess the current work plan and the full implementation of the Therap platform.

1. Incident Reports

The DSPDI has informed the JCC that it has an incidents protocol since April 2018. Incidents are documented in the Therap Services platform, and according to the JCAP, these reports should be investigated within forty-five (45) days to prevent serious incidents in future.

In the reports delivered to the JCC corresponding to the month of August 2019, the quality control area did not issue reports on the number of incidents, type of events, investigation reports and corrective plans. The vast majority of the reported incidents in the Therap platform do not have the required "corrective plan." Moreover, the reports lack particular specifications such as the identification of the "trigger", the conditions that generated the incident, and the corresponding follow-up. Unfortunately, incidents that provide data are still found, but they are missing the analysis that would help to understand the root cause of the incident and the measures that need to be taken to prevent recurrence in future. (See Section III, 4-A (2) of the JCAP. Docket No. 1185, at page 11).

a. Restraint Practice – Use of physical and chemical restraints. The JCC recognizes that the practice of physical restraints mechanism has been virtually eliminated, and the use of *Pro Re Nata* ("PRN") medication is still prohibited. However, it would be constructive to know about the use of the variety of psychiatric medications that participants use in the absence of a medical diagnosis.

Recommendations:

1. After three (3) years, the DSPDI only has one (1) coach for eight hundred twenty-four (824) users of the Therap platform. With the objective of accelerating the implementation plan of the Therap platform, it is necessary to have more coaches and a "Therap Services manager in every CTS" to oversee the adequate documentation, the proper updating of the information in the system, and to serve as a guide and support technician for providers and personnel of the CTS.

   In accordance with the JCAP, QA should review and analyze the incident reports to uncover patterns and trends; know the causes that triggered the incident; and help develop and implement remedies for prevention in the future. Although the JCC is aware that the DSPDI has protocols for responses to incidents, the results and the prevention action plans are still unknown to our Office. Likewise, the analysis of the data on incidents in the area of quality and the action plan is also unknown as of today.

BENCHMARKS: 40-52

E. Health Care and Mental Health Care

The objective of the Health and Mental Health Care provisions is for the Commonwealth to ensure quality services in the fields of physical and mental health for adults with DD.

One of the functions of the Therap platform is to provide a database of the medical and behavioral information of the participant such as: behavior plan and tracking, medical appointments, registration of glucose, height and weight, vaccines, infections, menstrual periods, respiratory treatment, as well as reporting incidents of behavioral changes.

Through the Therap platform, community physicians have been identified, and the DSPDI has established communications protocols.

- **CEEC**

The CEEC, described in the JCAP as a "clinical unit of specialized evaluation and mobility", has the responsibility of revaluating and reviewing if participants are receiving the adequate care with respect to physical and mental health. Likewise, it is expected that, as a team of experts, they provide support on crisis interventions, emergencies, and in the transition process of participants.

By 2017, the CEEC was changed to a "*Specialized clinic in evaluation and consulting,*" comprised of a multidisciplinary team, medical director, psychiatrist, nutritionist, occupational therapist, community nurse, social worker and a clinical coordinator in the field of psychology.

Unfortunately, in the Binder submitted in August 2019, by the DSPDI, there are no official reports issued by a CEEC physician, or by the psychiatrist and the nutritionist, therefore, the following information is unknown to the JCC:

- The work plan carried out during 2019;
- The number of participants (courts, ASSMCA, and the DSPDI) that were evaluated and/or reevaluated by the physician, the psychiatrist and the nutritionist;
- The number of consultation and clinical interventions being offered to participants;
- Crisis Line**:** the number of calls received by the emergency line, type of intervention provided, and the follow-up plan; and
- The use of the *Genesight* Test and how the results are being used.

Although the DSPDI did not submit reports, the participation of the CEEC is evident in documents where it is mentioned: attendance at meetings, trainings, and consults in the fields of psychology and nursing. Nevertheless, in accordance with the JCAP, the CEEC should be carrying out a more active role with greater participation in a broader sense.

As mandated by the JCAP, the DSPDI must provide a list of "high risk" participants. The following table illustrates the number of high-risk participants between the years 2018 and 2019, by physical condition (medical), mental condition (behavioral), risks of choking and diagnosis of epilepsy.

High Risk Participants

Year	Physical Condition	Behavioral	Choking Risk	Diagnose with Epilepsy
2019	359	16	101	250
2018	410	90	138	252

The DSPDI submitted a "High Risk and Longitudinal Report of Medications" as part of the compilation of information of treatment, intervention and data of the participants from the high-risk list. The value and usefulness of the information compiled in said report is recognized, however, this "longitudinal" report does not present a summary of the analysis of the information compiled through time[19]. For example: presenting the final number of participants who have had changes in their medications", "providing the number of participants that are under polypharmacy", "providing the number of participants that continue with the same amount of medication", and "indicating if the dosage of medication was increased or reduced." The objective of the JCAP is to use this information to help the participant, and to implement

[19] This report is 296 pages long. As it happens in other areas, the DSPDI sometimes furnishes information that, although appreciated by the JCC, it could be better handled if it were in a more condensed manner in order to be able to properly evaluate the furnished Information. The majority of these long reports contain much information but provide no results.

measures that meet the individual physical and mental needs so the CEEC can issue recommendations to the community physicians.

As of today's date, the JCC has identified a total of ninety (93) participants that are still using the medications Thorazin, Haldol and Mellaril. These participants are the same that appear in the list of December 2018, as well as in the most recent list of August 2019, both of which show that there has been no change or reduction in the use of these medications. According to the furnished report, have not presented adverse reactions according to the validation of the *Genesight* Test. The adverse reaction of medications should not be limited to the evaluation by means of a test. Other sources of analysis and evaluation should be presented as scientific evidence in order to properly assess the proper use of the above medications.

Studies have proven that persons with a diagnosis of intellectual disability have a greater probability, ranging from twenty-five (25%) to thirty percent (30%) of suffering from epilepsy in comparison with the general population (Luiselli, 2012). Since the year 2018, the DSPDI established an agreement with the "*Sociedad Puertorriqueña de Epilepsia*" in which the latter has been providing training to the personnel at the central level, parents and employees of the CTS. In the list delivered to the JCC dated April 30, 2019, the DSPDI reported having two hundred fifty (250) participants with a diagnosis of epilepsy who are offered neurological follow-up.

According to the information furnished by the DSPDI, there are one hundred one (101) participants identified with risks of choking, corresponding to the months from January to April 2019. According to the report from the Training Area, and pursuant to the JCAP, the DSPDI has been providing information through the following workshops: "Dysphagia and Swallowing Cycle", "dysphagia and nutrition" and "orientation on choking with dental focus." Although education is part of the prevention measures, the results of the impact of these workshops that would substantiate a reduction and/or elimination of the risk factors of these participants is still unknown. The JCC is of the opinion that including a speech pathologist within the CEEC team would be of great help for the swallowing/nutrition disorder that some participants currently face.

- **Nutrition**

Although the CEEC has a nutritionist for all DSPDI participants, no report was included in the August 2019, binder. During the visits to CTS and several homes, the JCC has observed that the food preparation is based on the available food and not on the model nutritional menu prepared by a nutritionist. A vast majority of the ID/DD population has one or more of these diagnoses: overweight, low weight, hypertension, constipation, dysphagia, diabetes, among other health conditions. Said diagnoses demands proper preparation and selection of food. The fact that the DSPDI only has one dietitian, no kitchen supervisors on some CTS, and the lack of proper equipment is also a concern for the JCC.

- **Mental**

Psychiatric disorders with persons with ID/DD are common and coexist with other mental disorders, which are not appropriately identified (Fletcher, Barnhill & Cooper, 2016) such as schizophrenia, depression, anxiety, attention deficit, dementia, posttraumatic stress, insomnia and adjustment disorder. Dual diagnosis should be taken into consideration during the process of evaluating participants.

DSPDI psychiatric data is often inconsistent. On October 2018, the DSPDI had a census of six hundred twenty-three (623) participants from which it identified fifty-seven (57) participants with a psychiatric diagnosis. On June 2019, the report from the psychology area prepared by Dr. Carmen Lassus, established a census of **one hundred seventy eight (178) participants who required mental health services from the seven CTS.** The DSPDI identifies one hundred nineteen (119) participants with dual diagnosis and seventy-two (72) participants that have predominantly a psychiatric diagnosis.

Pursuant to the directives of the Court, the JCC Office retained the services of Dr. Margarida, a clinical neuropsychologist with vast experience in the field of psychological assessment, to reevaluate participants that according to the DSPDI do not have an Intellectual Disability diagnosis. (See Docket No. 2482; and 2499). As of today's date, Dr. Margarida has evaluated two (2) of these twelve (12) participants and has determined that both participants do suffer from Intellectual Disability, contrary to the diagnosis provided by the DSPDI. Four (4) participants placed in a psychiatric hospital are on a waiting list to be placed in DSPDI homes according to a report submitted on July 8, 2019.The JCC will be paying close attention to all transitional procedures that will be used when transferring to a community home to ensure several safety and well-being factors that are repeatedly mandated by the JCAP.

Another issue of utmost concern to the JCC is the use of psychotropic drugs in the absence of psychiatric diagnosis and the practice of polypharmacy. This should not happen.This is evidenced in the Therap Services platform and in clinical records. Dr. Blanco and Dr. Javier Aceves previously provided reports regarding this situation. In addition, polypharmacy continues to be a major and troublesome problem within the DSPDI population.

- **Mortality and Comorbidity Committee (BM 86)**

Pursuant to the JCAP, the Mortality and Comorbidity Committee composed of eight (8) professionals from the DSPDI holds monthly meetings to discuss mortality reports. Pursuant to the furnished information, thirteen (13) deaths have been reported between the months of January to September 2019; three (3) of these deaths occurred at the Shalom Institution, and two (2) in the Institution of the Modesto Gotay Foundation. As of today's date, a total of one

hundred eight (108) reports are still pending to be submitted to the JCC[20]. The information on the number of deaths, number of reports submitted and the number of reports pending are presented in the following table:

Table: Mortality Reports (updated September 2019)[21]

Year	Deaths	Final Report	Reports pending
2019	*12	3	9
2018	20	18	2
2017	19	18	1
2016	14	1	13
2015	14	00	14
2014	20	2	18
2013	17	1	16
2012	15	00	15
2011	14	00	14
Total	146	38	108

In August 2019, Dr. Yocasta Brugal started working on the Mortality Committee; she will also be evaluating the cases of deaths, and will prepare the mortality reports along with Dr. Rodríguez Llauger.

One of the recommendations made by Dr. Rodríguez, was adding a community nurse to all institutions, and to provide follow-up services to the participants in this service model. Likewise, in a meeting between Dr. Rodríguez, the members of the JCC and the directors of DSPDI, the JCC expressed the importance of establishing regulations and a protocol to conduct a "root cause analysis" (BM 89 & 90, JCAP III.5.N.5). Dr. Rodríguez indicated that he expects to implement the analysis system by the end of November 2019. The JCC is currently awaiting information as to how the DSPDI will implement the recommendations set forth in the mortality reports.

[20] In the month of August 2019, the JCC was informed of a new member of the Mortality Committee, Dr. Yocasta Brugal, who will be evaluating the cases of deaths, and will prepare the mortality reports along with Dr. Rodríguez Llauger.

[21] The Office of the JCC included a participant's death that took place on September 9, 2019 in the Shalom home. The DSPDI did not include the same in its census. The present information was furnished by the Commonwealth on September 27, 2019.

Miscellaneous Initiatives:

1. Development of a Sexual Education Protocol and presentation to the CTS interdisciplinary team (year 2019). The JCC is interested in knowing about the implementation process and will continue to work with the DSPDI in said matter;
2. Creation of the "Nursing Services Manual and Norms of Procedures" by January 2019;
3. The DSPDI has a **Dental Clinic** in the facilities of the Central Offices. Dr. Molina has kept his commitment with the population suffering from intellectual disability. In August 2019, he informed the court that he has involved the College of Dental Surgeons of PR, and that the commission has identified new dentists throughout the Island to provide dental services to the adult population suffering from Intellectual Disability. Likewise, actions and efforts are being conducted with medical insurers to create a special coverage for those dentists that treat this population. He continues with his untiring work of awakening the interest with other dentists on how to render dental services to the population with ID/DD, and the JCC still awaits to see where this commendable effort ends;
4. Presentation and development of the Respite Program Proposal. Said proposal contemplates that the APIADI association will contribute valuable feedback and collaboration;
5. The Mortality and Comorbidity Committee has another physician for the assessment of cases and mortality reports; and
6. The Agreement that the DSPDI entered in to with the "*Sociedad Puertorriqueña de Epilepsia*" has proven effective and it has given needed support in the workshops provided to the DSPDI personnel, parents and relatives of the CTS. For the JCC this is a wonderful achievement, but we are awaiting to see the reach and results of the collaborative agreement.

BENCHMARKS: 53-65
BENCHMARKS: 66-99

F. System Wide Reforms

Since the year 2015, the DSPDI has been implementing the Therap Service platform. For the JCC it is of paramount importance that the DSPDI complies with the deadline set forth in the JAP (October 31) when the Platform should be in full operation and would help the DSPDI to be in compliance with the JCAP. Although there is a respite plan to be executed beginning in October, the implementation of such plan will be important in order to reach full compliance in this area of the JCAP as it has been done with the crisis Hotline.

BENCHMARKS: 100-106

IV. SUMMARY

As explained in the present Report, the JCC recognizes that the Commonwealth has shown some improvement in regards to several areas of the JCAP, which has increased their general compliance level from nineteen point six percent (19.6%) to twenty four percent (24%) from our last Report. The benchmarks that illustrate the most improvement are the ones pertaining to the preparation of mortality reports. For the first time in twenty (20) years, we have two (2) participants that are transitioning into independent living.

Although the above-mentioned areas have shown improvement, they are still distant from being classified at the compliance level pursuant to the mandates of the JCAP. Hence, as can be anticipated, there is still a lot of work to be done by the Commonwealth as illustrated in the present report. On the other hand, the present report still identifies numerous areas in the benchmarks in which the DSPSDI is still in partial or non-compliance after eight (8) years of the JCAP and almost twenty (20) years from the effective date of the Interim Supplemental Agreement (ISA). The slow progress that the Commonwealth has shown in the areas mentioned in the present report are worrisome and frustrating to the JCC. This pattern of slow compliance with the mandates of the JCAP must be significantly modified to meet the needs of the participants.

For the areas of the JCAP in which little or no progress has been achieved, the Office of the JCC still maintains the remedial recommendations set forth in pages 28-45 of our March 2019 Report. However, as for the issues that have been recently identified which were not part of the past reports, the JCC hopes that the present Report will serve as an instrument that will encourage the Commonwealth to properly and effectively address these situations to ensure that the essential services that the participants require are not curtailed, limited or impaired in any way or form.

Specifically, these areas pertain to: budgetary concerns; the deficiency in human resources and the lack of information regarding the same; the growing ID/DD population that will not be able to receive services; the opening of new homes; issues regarding payments to service providers; earthquake, hurricane and other natural disaster emergency plans; the full implementation of the TherapServices platform; issues regarding polypharmacy; the implementation of a respite program for relatives who have participants under their direct

care[22]; and more importantly the Commonwealth still using institutions as a placement option for new participants.

Commonwealth must assert all possible efforts to ensure the proper utilization of all of the Court protected resources to provide participants with all the required services and to obtain all the needed human resources without hesitation. Likewise, the Commonwealth must establish an effective mechanism to bring to the attention of the Secretary of Health concerning life and death situations that can affect participants. Furthermore, the Commonwealth's compliance with the Joint Action Plan will be of great help in moving forward with the pending matters that will further bolster the Commonwealth's compliance with the JCAP.

Full implementation of the TherapServices platform, would greatly benefit the Commonwealth and could greatly contribute to turning the CTS in to productive developmental centers pursuant to the JCAP (See Section II- C of the JCAP. Docket No. 1185, at page 6). The CTS's should offer services to participants five (5) days a week[23]. To this end, the Commonwealth should begin the year 2020 with the objective of creating five (5) capacity building days (eight (8) hours a day) in every CTS for every participant. Furthermore, the JCC expects a proactive management approach by the DSPDI.

The JCC feels commendsthe different parent associations' valuable and vital contributions to the present Reform and all of the essential work that they tirelessly provide for the benefit and well-being of the ID/DD population. Parent organizations such as APIADI (among others), as well as other family members of participants are an essential component of the reform process and should always be encouraged to participate in important discussions at all times pertaining to the deficiencies and problem areas that we identify in implementing the JCAP.

Notwithstanding the above, JCC is optimistic that with the additional professional resources that is currently retaining, and the willingness of the Commonwealth to receive assistance and support of from our office, all of the goals set forth in the JCAP can be achieved. Especially through proper transparent and open communications between the parties, our Office and parent organizations.

On a final note, the Federal Monitor's Office would like to recognize the great efforts and contributions exerted by Dr. Chiara Berríos, Ms. Von Marie Rivera, Esq., among other members of the DSPDI, and especially Ms. Idza Díaz, Esq., in helping the JCC in our efforts to assist the DSPDI in achieving greater compliance levels with the JCAP and in fulfilling our collective mission

[22] The JCC would like to quote one of the parents of the participants who mentioned that "the best respite program would be the proper functioning of the CTS".
[23] Currently, there is no uniformity between the CTS regarding the amount of days that participants are receiving services.

to provide better services and a higher quality of life to the participants who are at heart of the present reform and for whom all of our tireless efforts are directed.

V. ATTACHMENT 1:

There are one hundredth and six (106) benchmarks pertaining to action steps in the JCAP. The following table represents the level of compliance of each benchmark along with the JCC's remedial recommendations for each of item:

*Benchmarks with change in their compliance category from our March, 2019 report:

BENCHMARKS:

NUMBER	BENCHMARKS	COMPLIANCE	REMEDIAL RECOMENDATION(S)
1	Translate this benchmark document, as well as any updated versions, into Spanish	IN COMPLIANCE	
2	Disseminate both the English and Spanish versions of these benchmarks to all pertinent personnel	IN COMPLIANCE	
3	Create a "Master List" of all participants -- all persons with DD in the Commonwealth's IDP (or successor) -- and update quarterly; provide this list and all other lists	IN COMPLIANCE	

	below to JCC and US initially and as they are updated		
4	From the Master List, create a sub-list of all participants who live in an institution (e.g., Instituto Psicopedagogico, Modesto Gotay, Centro Shalom)	IN COMPLIANCE	
5	Issue a policy directive that all institutionalized participants can live in the community with adequate supports/services (JCAP III.1.A) (all cites below are to JCAP)	IN COMPLIANCE	
6	Develop a written individualized community transition plan for each participant in an institution using person-centered planning techniques (III.1.A, E)	PARTIAL COMPLIANCE	The JCC needs to see all participants' plans before we can make a proper recommendation.
7	For each participant, identify and document in the transition plan the individual and systemic obstacles to community placement from the institution (III.1.B)	PARTIAL COMPLIANCE	The JCC needs to see all participants' plans before we can make a proper recommendation.
8	For each participant, identify and document in the transition plan any family members/guardian opposed to community placement from the institution (if any) and the reason(s) for opposition (III.1.C)	PARTIAL COMPLIANCE	The JCC needs to see all participants' information in order to make a proper recommendation.
9	Meet with all family members/guardians opposed to community placement, provide them with education on expanded community capacity, and offer viable community residences to effect the placement of the participants from the institutions (III.1.C)	PARTIAL COMPLIANCE	The JCC does not have the information that was provided to the families, and/or guardians of participants.
10	Take the opposed families/guardians on tours of	PARTIAL COMPLIANCE	For All Participants.

	prospective, successful community residences (III.1.C)		
11	For each appropriate participant, overcome all necessary obstacles (other than entrenched guardian opposition) to effect community placement from the institution in a manner consistent with Olmstead and the CBSP (III.1.B)	PARTIAL COMPLIANCE	All appropriated participants.
12	Monitor all participants placed in the community to ensure they receive all the necessary protections, supports, services to meet their individualized needs in community settings (III.1.E)	IN COMPLIANCE	
NUMBER	BENCHMARK	COMPLIANCE	REMEDIAL RECOMENDATION(S)
13	From Master List, create sub-list of all participants living in the community, specifying name and location of each person's residential provider and total number of individuals living in each home	IN COMPLIANCE	
14	Develop a systemwide plan to increase the number of community residential providers to meet participants' individualized needs (III.2)	IN COMPLIANCE	
15	Implement the plan to reduce the number of individuals in each community group and substitute home to meet individualized needs, to increase the level of individual attention devoted to participants day-to-day, to create a more peaceful and therapeutic living environment, and to improve outcomes for participants day-to-day (III.2); each participant	NO COMPLIANCE	There are still Homes with 8 or 9 participants.

	shall have a private or semi-private bedroom		
16	Ensure that community homes: provide participants with adequate protections, supports, services; meet their individualized needs; ensure their health, safety, welfare; provide increased individual attention; provide a more peaceful and therapeutic living environment; improve outcomes (III.2)	PARTIAL COMPLIANCE	There are still participants living without the necessary equipment for their specific condition.

NUMBER	BENCHMARK	COMPLIANCE	REMEDIAL RECOMENDATION(S)
17	From the Master List, create a sub-list of those who are currently working in the community, specifying the name and location of the employer, the number of hours per week the participant is working, and the participant's hourly wage or compensation rate	IN COMPLIANCE	
18	For those working in the community, develop individualized action steps to ensure no one working in the community is underdemployed (III.3.A)	PARTIAL COMPLIANCE	Present vidence of individualized plan focused on participant and individualized action steps.
19	Implement the action steps to ensure that no one working in the community is underemployed (with the understanding that the Commonwealth cannot guarantee optimal employment, but nonetheless will continue its efforts to avoid underemployment) (III.3.A, B)	PARTIAL COMPLIANCE	Evidence of implemented individualized action steps have been identified.

20	From the Master List, create a sub-list of those who are currently not working in the community, but have been professionally assessed or identified in the past as able to work in the community; designate on this sub-list the date/author(s) of the most recent assessment	SUBSTANTIAL COMPLIANCE	Present evidence of the use of scientifically validated instruments and professional training of staff.
21	Professionally assess or re-assess for community employment all participants who are currently not working in the community, but have been professionally assessed or identified in the past as able to work in the community (III.3.C)	*PARTIAL COMPLIANCE	Present evidence of assessment or re-assessment for community employment of all participants who are currently not working in the community. Present evidence of the use of scientifically validated instruments and the professional training of staff
22	Develop individualized, concrete action steps with timeframes to maximize their community employment (III.3.C)	*PARTIAL COMPLIANCE	Present evidence regarding the development of individualized concrete action steps.
23	Implement the action steps to ensure that: everyone who is able to work is working in the community; and everyone working in the community is not underemployed (with the understanding that the Commonwealth cannot guarantee employment, but nonetheless will continue its efforts to find paid employment and avoid underemployment) (III.3.D)	SUBSTANTIAL COMPLIANCE	Present evidence of the use of scientifically validated instruments and the professional training of staff.
24	From the Master List, create a sub-list of all other participants who are currently not working in the community; designate on this sub-list the date/author(s) of the most recent professional employment assessment, if any; designate those	SUBSTANTIAL COMPLIANCE	Present evidence of the use of scientifically validated instruments and the professional training of staff

	who have been professionally assessed as not able to work in the community		
25	Professionally assess or re-assess for community employment all of these other participants who are not currently working in the community (III.3.C)	PARTIAL COMPLIANCE	Present evidence of the use of scientifically validated instruments and the professional training of staff
26	For those with professional assessments that they can work in the community, develop individualized, concrete action steps with timeframes for these other participants to maximize their community employment (III.3.A)	SUBSTANTIAL COMPLIANCE	Once assessments are in place, develop individualized, concrete action steps.
27	Implement the action steps to ensure that: everyone who is able to work is working in the community; and everyone working in the community is not underemployed (with the understanding that the Commonwealth cannot guarantee employment, but nonetheless will continue its efforts to find paid employment and avoid underemployment) (III.3.D)	*PARTIAL COMPLIANCE	Evidence of implementation
28	Develop and implement a program to promote self-employment for approporiate participants, specifying the number of times per trimester each participant is to be engaged in community self-employment activities; examples of self-employmnet may include, but not be limited to, work at fairs and urban markets selling arts and crafts participants create.	PARTIAL COMPLIANCE	Strengthen self-employment workshops. Present evidence of the use of scientific validated instruments and the professional training of staff
29	Systemwide, work to implement the goal of having at least 25	PARTIAL COMPLIANCE	Employment goal: 25%

	percent of all participants of working age employed in the community, on a full-time or part-time basis based on individualized needs, at minimum wage or above, at a location where the employee interacts with individuals without disabilities and has access to the same opportunities for benefits and advancement provided to workers without disabilities (with the understanding that the Commonwealth cannot guarantee employment, but nonetheless will continue its efforts to find paid employment and avoid underemployment)		
30	For those participants with professional assessments that they are not able to work in the community, develop individualized plans to maximize meaningful, functional community activities that foster their growth and independence (III.3.E)	PARTIAL COMPLIANCE	Present evidence of ndividualized plans of meaningful and functional community activities that foster their independent living.
31	Implement the plans (III.3.E)	PARTIAL COMPLIANCE	Evidence of implementation of the plans.
32	For those participants who are not working in the community but attend a day program at a CTS, ensure that these participants attend the day program according to his/her individualized needs; ensure that staffing, transportation, and other resources are adequate to meet individualized needs; ensure that buses have ramps and other needed accessibility supports	PARTIAL COMPLIANCE	Attend a CTS according to participant's individual needs, not CTS service availability. Transportation and adequate staffing.
33	From the Master List, create a sub-list of those who do not work or	IN COMPLIANCE	

	participate in formal day program activities at a CTS and assess why they do not and remain at home (III.3.F)		
34	Develop individualized plans for these participants to maximize meaningful, functional community activities that foster their growth and independence (III.3.F); ensure that participants engage in such community activities at least two times per month	SUBSTANTIAL COMPLIANCE	Evidence of idividualized plans with meaningful, functional community activities.
35	Implement the plans (III.3.F)	SUBSTANTIAL COMPLIANCE	Evidence of implementation of the plans.
36	Develop a systemwide plan for all participants to maximize non-work activities in the community that are meaningful, functional, and foster growth and independence to meet individualized needs (III.3.G)	*PARTIAL COMPLIANCE	Present evidence of action of plans for all participants to maximize non-work meaningful, functional activities that foster their independent living.
37	Implement the plan (III.3.G)	*PARTIAL COMPLIANCE	Present evidence of the implementation of the plans.
38	Ensure that staffing, transportation, other resources are adequate and reliable to meet individualized needs for integrated day activities in the community (III.3.H); ensure that buses have ramps and other needed accessibility supports	*PARTIAL COMPLIANCE	Listed evidence of adequate staffing, transportation and other resources regarding participants individualized needs.
39	Ensure there are sufficient job coaches and job trainers to meet individualized needs in the community (III.3.I)	PARTIAL COMPLIANCE	Present evidence of the adequate staffing vs participants. and the professional training of staff.

NUMBER	BENCHMARK	COMPLIANCE	REMEDIAL RECOMENDATION(S)
40	Using data from Therap combined with onsite assessments, conduct a safety and welfare analysis of all	PARTIAL COMPLIANCE	1. Stable internet system 2. More Laptops and computers in all CTS

	individual participants and their residences (III.4.A)		3. All providers and employees should use therap system consistently and as part of standard method of data entry. 4. Using data from Therap combined with onsite assessments, conduct a safety and welfare analysis of all individual participants and their residences (III.4.A).
41	Implement measures to ensure participant safety and welfare based on this analysis (III.4.A)	PARTIAL COMPLIANCE	The JCC needs evidence of Implemented measures to ensure participant safety and welfare based on this analysis (III.4.A)
42	Using data from Therap combined with first-hand accounts, analyze peer-to-peer interactions that create risk of harm (III.4.A.1)	PARTIAL COMPLIANCE	The JCC present evidence of using data from Therap and the result of the analysis.
43	Implement effective measures to address peer-to-peer risk factors to prevent harm (III.4.A.1)	PARTIAL COMPLIANCE	Improve quality Control Area and present evidence of Implement effective prevention plan.
44	Using data from Therap combined with first-hand accounts, identify vulnerable participants at risk of harm (III.4.A.2)	SUBSTANTIAL COMPLIANCE	The JCC needs evidence of Implementation using data from Therap combined with first-hand accounts, identify vulnerable participants at risk of harm (III.4.A.2)
45	Implement effective measures to minimize/ eliminate their risk factors (III.4.A.2)	SUBSTANTIAL COMPLIANCE	Evidence of action plan to implemented effective measures to minimize/ eliminate their risk factors (III.4.A.2)
46	Using data from Therap combined with first-hand accounts, identify aggressor participants (III.4.A.3)	IN COMPLIANCE	
47	Implement effective measures to minimize/eliminate aggressor risk triggers (III.4.A.3)	PARTIAL COMPLIANCE	Created individualized plans to minimize/eliminate aggressor risk triggers (III.4.A.3)
48	Informed by data from Therap, develop a systemwide plan to ensure that serious incidents, per JCAP criteria, are reported promptly and investigated within	SUBSTANTIAL COMPLIANCE	Quality Control Area of DPSDI Present evidence of data from Therap and develop a systemwide plan to ensure that serious

	45 days, all to prevent serious incidents in the future (III.4.B)		incidents are reported promptly and investigated within 45 days.
49	Informed by data from Therap, develop a systemwide plan to analyze incident patterns and trends to prevent incidents in the future (III.4.B)	IN COMPLIANCE	
50	Implement these systemwide plans and implement remedial measures to address any individual and/or systemic issues that arise from the investigations and incident analysis to ensure participant safety and welfare and minimize/eliminate abuse and neglect (III.4.B)	SUBSTANTIAL COMPLIANCE	Quality Control Area and CEEC, Apply the system wide plans and present evidence of remedial measures from the investigations and incident analysis
51	Implement effective measures to minimize/eliminate use of all restraints on participants (III.4.C)	IN COMPLIANCE	
52	Prohibit use of standing PRN or "stat" orders for chemical restraints on participants (III.4.C)	IN COMPLIANCE	

NUMBER	BENCHMARK	COMPLIANCE	REMEDIAL RECOMENDATION(S)
53	From the Master List, create a list of all participants and their current community clinicians, highlighting the primary care physicians and neurologists, if applicable (III.5.B)	IN COMPLIANCE	
54	Through Therap and/or other means, implement an effective communication system to promptly alert all community clinicians and other pertinent personnel to significant changes in the health status of individual participants across the system (III.5.A)	PARTIAL COMPLIANCE	Implement an effective communication system to promptly alert all community clinicians and other pertinent personnel to significant changes in the health status of individual participants across the Therap system (III.5.A)
55	Whenever there is a significant change in participant health	PARTIAL COMPLIANCE	Listed evidence that appropriate treatment and other measures are

	status, ensure that appropriate treatment and other measures are provided promptly to meet the individualized needs of the participant		provided promptly to meet the individualized needs of the participant
56	Implement an effective system to gather and provide to pertinent community clinical personnel all individual participant information for use in monthly or more frequent appointments (III.5.B); participant information may be located in the home, CTS, CEEC, Central Office, and/or elsewhere	SUBSTANTIAL COMPLIANCE	CEEC and CTS employees: Evidence of system plan to gather and provide to pertinent community clinical personnel all individual participant information for use in monthly or more frequent appointments (III.5.B);
57	Maintain effective communication with community clinicians to determine if they provide informed and comprehensive individualized evaluations and treatment that meet individualized participant needs (III.5.B)	SUBSTANTIAL COMPLIANCE	CEEC and CTS employees, Evidence of effective communication with community clinicians to determine if they provide informed and comprehensive individualized evaluations and treatment that meet individualized participant needs (III.5.B)
58	Ensure participants receive necessary health care in a timely manner to meet their individualized needs in the community (III.5.G)	SUBSTANTIAL COMPLIANCE	CEEC team and health professionals become more proactive and provided follow-up to the treatment plans, evaluation and reassessment and communication with community doctors.
59	From the Master List, create sub-lists of priority at-risk participants in the community, per JCAP criteria, that require heightened, enhanced attention and focus (III.5.H); priority at-risk condition criteria are set forth in JCAP III.5.H	IN COMPLIANCE	
60	Through Therap and other means, implement a systemwide plan to work with community clinicians to promptly and proactively develop	SUBSTANTIAL COMPLIANCE	Evidence through Therap and other means; implement a systemwide plan to work with community clinicians to promptly and proactively develop and

	and implement tailored and intensive protections, supports, services for priority at-risk participants to meet their individualized needs (III.5.I)		implement tailored and intensive protections, supports, services for priority at-risk participants to meet their individualized needs (III.5.I)
61	Monitor to ensure that priority at-risk conditions are minimized or eliminated; document and track seizures, bowel obstructions, aspiration and aspiration pneumonia, decubitus ulcers, other conditions per JCAP criteria (III.5.I)	SUBSTANTIAL COMPLIANCE	CEEC and Physcian; Listed evidence to ensure that priority at-risk conditions are minimized or eliminated; document and track seizures, bowel obstructions, aspiration and aspiration pneumonia, decubitus ulcers, other conditions per JCAP criteria (III.5.I)
62	Establish a program of traveling nurses (from the CEEC and/or the CTS sites) to regularly conduct onsite visits with participants in their homes and/or day programs to assess, treat, and monitor their services and supports to ensure that the individualized needs of each priority at-risk participant are met day-to-day; these nurses are to provide ongoing technical assistance to community providers whenever needed, especially when there is a decline in health status; in biological homes, this service will be provided with the authorization of the parents, family members, or custodians	*SUBSTANTIAL COMPLIANCE	Strengthen program of traveling nurses (from the CEEC and/or the CTS sites) to regularly conduct onsite visits with participants in their homes and/or day programs to assess, treat, and monitor their services and supports to ensure that the individualized needs of each priority at-risk participant are met day-to-day; these nurses are to provide ongoing technical assistance to community providers whenever needed, especially when there is a decline in health status; in biological homes, this service will be provided with the authorization of the parents, family members, or custodians
63	Using data from Therap and other sources, regularly compile and analyze incident, outcome, intervention, treatment information for each priority at-risk person (III.5.J)	*SUBSTANTIAL COMPLIANCE	Evidence of using data from Therap and other sources, regularly compile and analyze incident, outcome, intervention, treatment information for each priority at-risk person (III.5.J)

64	Regularly share this information with community clinicians (III.5.J)	PARTIAL COMPLIANCE	Evidence in clinical records that regularly share this information with community clinicians (III.5.J)
65	Maintain effective communication with community clinicians to determine if they utilize this information to implement measures to meet individualized participant needs (III.5.J)	PARTIAL COMPLIANCE	CEEC Promote communication with community clinicians to determine if they utilize this information to implement measures to meet individualized participant needs (III.5.J)

NUMBER	BENCHMARK NEUROLOGICAL CARE	COMPLIANCE	REMEDIAL RECOMENDATION(S)
66	From the Master List, create a sub-list of all participants with a seizure disorder/epilepsy, specifying any anticonvulsant medications they receive with dosage(s) (III.5.K)	IN COMPLIANCE	
67	Ensure that neurologists provide participants with a seizure disorder with comprehensive neurology evaluations as needed, at least annually (III.5.K)	IN COMPLIANCE	
68	Using data from Therap and other sources, compile a sub-list of those participants who have had more than 10+ seizures in the past year, as well as a sub-list of those who have had no seizures for the past two years (III.5.K.1)	SUBSTANTIAL COMPLIANCE	Evidence of using data from Therap and other sources, compile a sub-list of those participants who have had more than 10+ seizures in the past year, as well as a sub-list of those who have had no seizures for the past two years. (III.5.K.1).
69	Ensure that neurologists provide effective care for those having 10+ seizures per year (III.5.K.1)	IN COMPLIANCE	
70	Ensure that neurologists provide effective care for those who have not had a seizure in the past two years (III.5.K.1)	IN COMPLIANCE	
71	Ensure that neurologists weigh the benefits of medication use and	PARTIAL COMPLIANCE	Physician and CEEC Listed evidence that neurologists weigh the benefits of medication

	adequately document the rationale for anticonvulsant medication (III.5.K.2)		use and adequately document the rationale for anticonvulsant medication (III.5.K.2)
72	Ensure the use of intra-class polypharmacy is minimized and fully justified (III.5.K.2)	PARTIAL COMPLIANCE	Physician and PharmD Listed evidence that intra-class polypharmacy is minimized and fully justified (III.5.K.2)
73	Formalize a relationship with the Epilepsy Foundation of Puerto Rico and use the relationship to improve neurological care and outcomes for participants (II.5.K.3)	IN COMPLIANCE	

NUMBER	BENCHMARK ASPIRATION RISKS	COMPLIANCE	REMEDIAL RECOMENDATION (S)
74	From the Master List, create a sub-list of those participants at risk of aspiration and/or aspiration pneumonia	IN COMPLIANCE	
75	Implement individualized plans to eliminate unsafe mealtime practices, per JCAP criteria, to minimize risk of aspiration/pneumonia (III.5.L)	PARTIAL COMPLIANCE	Need of Speech Language Pathologist in CEEC Implement individualized plans to eliminate unsafe mealtime practices, to minimize risk of aspiration/pneumonia (III.5.L)
76	Implement individualized plans to keep non-ambulatory individuals in proper alignment to minimize risk of aspiration/pneumonia (III.5.L)	PARTIAL COMPLIANCE	Nutritionist of CEEC Evidence of Implementation: individualized plans to keep non-ambulatory individuals in proper alignment to minimize risk of aspiration/pneumonia (III.5.L)

NUMBER	BENCHMARK CEEC	COMPLIANCE	REMEDIAL RECOMENDATION(S)
77	Ensure CEEC regularly evaluates all participants (III.5.C); compile list of ongoing evaluations	*SUBSTANTIAL COMPLIANCE	Ensure CEEC regularly evaluates all participants (III.5.C); evidence of ongoing evaluations
78	Ensure CEEC regularly reviews the adequacy and appropriateness of individualized community health care and mental health care	*SUBSTANTIAL COMPLIANCE	Ensure CEEC regularly reviews the adequacy and appropriateness of individualized community health

	(III.5.C); compile list of ongoing reviews		care and mental health care (III.5.C) Evidence of ongoing reviews
79	Ensure CEEC promptly raises red flags and actively advocates on behalf of individuals when community services do not meet their individualized needs (III.5.C); compile list of ongoing instances of contacting community clinicians to raise red flags/advocate for participants, summarizing result of contact	*SUBSTANTIAL COMPLIANCE	Evidence that CEEC promptly raises red flags and actively advocates on behalf of individuals when community services do not meet their individualized needs (III.5.C); Listed evidence of ongoing instances in contacting community clinicians to raise red flags/advocate for participants, summarizing result of contact. Implement the plan.
80	Ensure CEEC informs community clinicians of recent adverse health or mental health outcomes that may implicate treatment (III.5.E); compile list of ongoing instances where CEEC informed community clinicians, summarizing result of contact	PARTIAL COMPLIANCE	CEEC (III.5.E) Listed evidence of ongoing instances where CEEC informed community clinicians and summarizing result of contact
81	Develop and implement effective systemwide plan for CEEC to promptly communicate concerns to community clinicians that improve outcomes (III.5.E); compile list of improved outcomes after CEEC intervention	PARTIAL COMPLIANCE	CEEC Present evidence of an effective wide system plan to promptly communicate concerns to community clinicians that improve outcomes (III.5.E); Evidence of list of improved outcomes after CEEC intervention
82	Implement a systemwide protocol to alert licencing, ombudsman agencies of community clinician improprieties (III.5.F); compile list of alerts	PARTIAL COMPLIANCE	Implement a system wide protocol to alert licensing, ombudsman agencies of community clinician improprieties (III.5.F); compile list of alerts
83	Ensure CEEC serves as a mobile crisis team, providing prompt, effective, flexible, individualized, mobile, expert support, services, and advice at community sites during emergencies, crises, transitions to meet individualized	SUBSTANTIAL COMPLIANCE	Evidence that CEEC serves as a mobile crisis team and compile list of mobile crisis team visits/interventions.

	needs on a 24/7 basis (III.5.C); compile list of mobile crisis team visits/interventions, summarizing result		
84	Ensure CEEC mobile crisis team is comprised of multi-disciplinary group of DD professionals (III.5.D)	SUBSTANTIAL COMPLIANCE	Listed evidence that CEEC mobile crisis team is compromised in a multi-disciplinary group of DD professionals (III.5.D)
85	Ensure CEEC mobile crisis services maximize individuals' ability to live succesfully in the community (III.5.D); compile list of instances where mobile crisis team intervention resulted in diversion from an institutional setting or prevented an adverse outcome	SUBSTANTIAL COMPLIANCE	Listed evidence CEEC mobile crisis services maximize individuals' ability to live successfully in the community (III.5.D)

NUMBER	BENCHMARK MORTALITY REVIEW	COMPLIANCE	REMEDIAL RECOMENDATION(S)
86	Create and maintain a mortality review committee comprised of well-respected health care and quality review personnel, headed by an independent chairperson (III.5.N)	IN COMPLIANCE	
87	Ensure MRC meets regularly and conducts an in-depth review of each death, per JCAP criteria, identifying individual and systemic issues related to each death (III.5.N.2, 4); compile list of MRC meetings and death reviews	SUBSTANTIAL COMPLIANCE	Continue to present evidence of the MRC meetings regularly, compile list of MRC meetings and death reviews.
88	Ensure MRC has access to all pertinent people, information related to the course of care leading up to the death (III.5.N.3)	IN COMPLIANCE	
89	Ensure MRC performs a root-cause analysis to identify any preventable causes of illness and death (III.5.N.5)	NO COMPLIANCE	Create a pathway so that the MRC performs a root-cause analysis to identify any preventable causes of illness and death (III.5.N.5)

90	Ensure MRC issues a final report on each death promptly, per JCAP criteria, with root-cause analysis and recommendations to address outstanding issues (III.5.N.5)	NO COMPLIANCE	Create a pathway so that the MRC issues a final report on each death promptly, per JCAP criteria, with root-cause analysis and recommendations to address outstanding issues (III.5.N.5)
91	Monitor to ensure prompt and effective implementation of all MRC recommendations and continue to monitor until full implementation (III.5.N.7); complie tracking table of recommendations and implementation status	NO COMPLIANCE	Evidence of implementation of all MRC recommendations and continue to monitor until full implementation (III.5.N.7); compile tracking table of recommendations and implementation status
92	Monitor to ensure MRC process is effective to avoid preventable illnesses, deaths for similarly situated individuals (III.5.N)	NO COMPLIANCE	Present evidence of action plans and its result that guarantee that the MRC process is effective in avoiding preventable illnesses, morbidities and mortalities.

NUMBER	BENCHMARK MENTAL HEALTH	COMPLIANCE	REMEDIAL RECOMENDATION(S)
93	From the Master List, create a sub-list of all participants with mental illness, specifying their mental illness diagnosis/es (III.5.G)	PARTIAL COMPLIANCE	Present an updated list From the Master List, create a sub-list of all participants with mental illness, specifying their mental illness diagnosis (III.5.G)
94	Ensure participants receive necessary mental health care in a timely manner to meet their individualized needs in the community (III.5.G)	SUBSTANTIAL COMPLIANCE	Present evidence to ensure that participants received necessary mental health care in a timely manner to meet their mental care needs (III.5.G)
95	Ensure that all mental illness diagnoses are consistent with DSM criteria and justified in the record (III.5.M)	NO COMPLIANCE	Psychiatrist evaluation to ensure that all mental illness diagnoses are consistent with DSM criteria and justified in the record (III.5.M)
96	Ensure that no participant receives psychotropic medication in the absence of a clinically justifiable diagnosis of mental illness (III.5.M)	PARTIAL COMPLIANCE	Psychotropic medicine reconciliation by a PharmD and/or Psychiatrist to ensure that no participant receives psychotropic medication in the

			absence of a clinically justifiable diagnosis of mental illness (III.5.M)
97	Ensure that type, dosage of psychotropic medication are appropriate and needed for each participant, per JCAP criteria (III.5.M)	NO COMPLIANCE	Psychotropic medicine reconciliation by a PharmD and/or Psychiatrist to ensure that type, dosage of psychotropic medication are appropriate and needed for each participant, per JCAP criteria (III.5.M)
98	Minimize use of typical/first generation psychotropic medication (III.5.M)	SUBSTANTIAL COMPLIANCE	Plan of Psychiatrist in order to present efforts to minimize use of typical/first generation psychotropic medication (III.5.M)
99	Minimize use of intra-class psychotropic medication polypharmacy (III.5.M)	PARTIAL COMPLIANCE	Psychotropic medicine reconciliation by a PharmD. Plan to Minimize use of intra-class psychotropic medication polypharmacy (III.5.M)

NUMBER	BENCHMARK	COMPLIANCE	REMEDIAL RECOMENDATION(S)
100	Implement a comprehensive quality assurance program to track, analyze, and ensure participant safety, welfare, health care, mental health care issues and outcomes (III.6.A)	PARTIAL COMPLIANCE	Full Implementation of the Therap Service
101	Implement prompt and effective measures to address patterns and trends that adversely impact participant safety, welfare, health, and mental health (III.6.A)	PARTIAL COMPLIANCE	Full Implementation of the Therap Service
102	Ensure that each participant receives adequate and appropriate monitoring and oversight by a service mediator to meet individualized needs; per existing Court orders, ensure that each service mediator serves no	PARTIAL COMPLIANCE	Have the necessary personnel (mediators)

	more than 24 participants at any time		
103	Work with family members of participants on a plan to address quality issues that impact participants	PARTIAL COMPLIANCE	Full implementation of the Respite program
104	Create and maintain toll-free crisis hotline, staffed 24/7 by qualified professionals that can effectively help to resolve issues (III.6.B	IN COMPLIANCE	
105	Create and maintain a systemwide email system to facilitate prompt communication to all pertinent individuals, per JCAP criteria to resolve outstanding issues (III.6.C)	SUBSTANTIAL COMPLIANCE	Full Implementation of the Therap Service
106	Develop a family support program consistent with the criteria in the CBSP (V) that includes service mediators for participants living at home, as well as a subsity and respite program; participation in the program will be voluntary and with prior authorization in private homes	SUBSTANTIAL COMPLIANCE	Full implementation of the Respite program