



# DISABILITIES LAW PROGRAM

COMMUNITY LEGAL AID SOCIETY, INC.

100 W. 10th Street, Suite 801

Wilmington, Delaware 19801

(302) 575-0660 TTY (302) 575-0696 Fax (302) 575-0840

www.declasi.org

## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Regulatory & Policy Initiatives

Date: October 4, 2014

I am providing my analysis of six (6) regulatory and policy initiatives. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

### 1. DMMA Final PASRR Regulation [18 DE Reg. 305 (10/1/114)]

The SCPD and GACEC commented on the proposed version of this regulation in August. A copy of the August 28, 2014 SCPD memo is attached for facilitated reference. The Division of Medicaid & Medical Assistance (DMMA) has now adopted a final regulation incorporating some edits prompted by the commentary.

First, the Councils observed that a reference was ostensibly missing from the definition of "convalescent care". DMMA agreed and inserted the words "convalescent care".

Second, the Councils recommended clarification of which agency issues the final PASRR decision. DMMA amended the regulatory language.

Third, the Councils recommended that the regulation be amended to confirm that final PASRR determinations are appealable through 16 DE Admin. Code 5000. DMMA adopted the Councils' proposed amendment verbatim.

Fourth, the Councils suggested that DMMA consider revising 16 DE Admin. Code 5304.1 in the future to clarify which agency issues a final decision. DMMA noted that DSAMH and DDDS PASRR decisions "cannot be countermanded by the State Medicaid agency." At 309. DMMA agreed to consider an amendment "as the agency develops procedures for processing (a) PASRR-related Fair Hearings." At 309.

Since the regulation is final, and DMMA addressed each comment proffered by the Councils, I recommend no further action.

2. DLTCRP Prop. Rest (Family) Care Home Regulation [18 DE Reg. 282 (10/1/14)]

The Division of Long-term Care Residents Protection is proposing a complete revision to its standards covering rest (family) care homes. The Division notes that the current standards, last amended in 1993, are outdated. At 283.

I have the following observations.

1. In §3.1.2.1.1, consider the following amendment: “Violation of any of the provisions of these rules and regulations or 16 Del.C. Ch. 11.” I recognize that the regulations address the Patient Bill of Rights in §8.0 and that §4.3 is expansively written. However, it may facilitate enforcement and DHSS defense of appeals under §3.1.2.3 if compliance with Chapter 11 is explicitly highlighted. For example, the regulations do not address failure to comply with mandatory reporting (16 Del.C. §1132) or criminal background check standards (16 Del.C. §1141).
2. Section 4.4 could be improved. The following sentence could be added: “The level of care determination shall be made in consultation with the resident’s personal primary care licensed independent practitioner, if any.” Otherwise, the implication is that an agent of the placement agency (who may have marginal familiarity with the resident) may determine level of care based on a “1-stop” assessment lacking the long-term familiarity enjoyed by a PCP.
3. In §4.7, consider substituting “admission to” for “placement in”. Individuals may voluntarily solicit admission to a family care home. The term “placement in” suggests an involuntary or agency-directed admission. This section covers individuals whose admission is not prompted by an agency.
4. In §5.4.6.1, I suspect the term “bcated” should be “located”.
5. Section 5.4.6.2 addresses the slope of any required ramp which generally tracks the historical ADA 1 foot rise in 12 foot run standard. However, there are other “safety” aspects to ramps that could be included. See attachment downloaded from <http://www.ada-compliance.com/ada-compliance/ada-ramp>. The most obvious is the requirement of handrails, 36" width, and edge protection. Compare §5.9.1 (requiring handrails in stairways).
6. Section 5.6 would categorically disallow use of a portable air conditioner. Individuals vary considerably in their tolerance for heat/cold. Disallowing a room air conditioner undermines “choice” among residents and ignores variations of temperature within a home which uses a central system. For example, an upstairs bedroom facing south or west will generally be hotter than a downstairs room facing east or north. Literally, §5.6 could be interpreted to mean that a resident could not complain if his/her room is 80 degrees in the summer. A room air conditioner simply provides some flexibility. Similar regulations [16 DE Admin Code 3320, §6.10] do not ban even portable heating devices.

7. The regulations do not address stairglides, stairlifts and elevettes/elevators. The Division may wish to consider whether standards should be included.

8. In §5.9.6 delete the apostrophe in “Camera’s”.

9. Section 5.10 could be improved by explicitly disallowing bunk beds. Compare 16 DE Admin Code 3320, §6.6.6. Otherwise, a provider could use bunk beds to circumvent other bedroom standards.

10. Section 5.10.12 allows three (3) residents per bedroom. This is highly objectionable. It is not “normal” for three adults to share a bedroom. Compare 16 DE Admin Code 3310, §8.3 and 3230, §5.8.8. There is also some “tension” between this standard and §§4.9 and 8.12. Moreover, the definition of “family care home” refers to “a family living situation”, not a dorm or institutional environment.

11. Section 5.11.3.2 has multiple plural pronouns (they; their) with a singular antecedent (resident). Consider the following substitute: “A resident may choose to provide an individual mattress to be used only by that resident.”

12. Section 5.12 allows 1 toilet and 1 bathtub/shower for every eight (8) occupants. This is highly objectionable. Many of the residents will require assistance with bathing and toileting so “turnover” of the shower and toilet may be very slow. By analogy, the neighborhood home regulation requires 1 toilet and 1 bathtub/shower for every four (4) individuals. See 16 DE Admin Code 3310, §9.0. See also 16 DE Admin Code 3230, §5.9, and 16 DE Admin Code 3301, §5.9. Imagine three (3) residents (§2.0, definition of “family care home) with limited capacities competing with five (5) family members (§2.0, definition of “occupant”) for the bathroom every morning as they try to get ready for work or travel to a day program. Typically, the toilet will be in the same room as the shower/bathtub so no one will be able to use the toilet while someone is showering. This is an untenable arrangement.

13. Section 5.15.6.4 allows the provider to complete laundry for residents. This standard should be embellished to ban commingling of laundry (including underwear) which can result in spread of disease, including C-Diff. See attached CDC Q&A documented published at [http://www.cdc.gov/HAI/organisms/cdiff/Cdiff\\_faqs\\_HCP.html](http://www.cdc.gov/HAI/organisms/cdiff/Cdiff_faqs_HCP.html). Such embellishment would further the objectives of §7.1.5.3 and §8.14. Temperature and bleach standard could also be included. See 16 DE Admin Code 3201, §7.6 and 16 DE Admin Code 3301, § 5.12.6.

14. Section 7.1.4 should be revised to refer to the “licensed independent practitioner” rather than simply “physician”.

15. Section 7.1.3 does not offer much flexibility if a resident wishes to keep his/her own medications. This is inconsistent with the definition of “family care provider” which adopts a standard of promoting maximum independence through individual choice. By analogy, the assisted living regulation [16 DE Admin Code 3225, §8.4] allows some residents to keep medications in a purse or facility-provided container.

I recommend sharing the above observations and recommendations with the Division.

3. DOE Prop. State Assessment System Regulation [18 DE Reg. 279 (10/1/14)]

The Department of Education is proposing revisions to the State Assessment System standards to implement both H.B. No. 334 and S.B. No. 229 enacted in the summer of 2014. The latter legislation stirred more debate. See attached June 15, 2014 News Journal article. The GACEC and other stakeholders provided input on prepublication drafts of the proposed regulation prompting some earlier amendments.

I have the following observations on the published proposed regulation.

1. In §1.2, the definition of “District Test Coordinator (DTC)” is counterintuitive since it includes a charter school educator. I recommend substituting “Local Agency Test Coordinator (LATC)” or “Agency Test Coordinator (ATC)”.

2. The regulations contain many references to “School Test Coordinator”. See, e.g., §§10.1, 10.2, 10.5, 12.1.1.2, 12.1.1.2.1, and 12.2.2. There is no definition of the term. A definition should be added. For example, the definition of “District Test Coordinator” requires completion of certain training. There is no equivalent requirement for a “School Test Coordinator” since the term is undefined. Moreover, it is unclear if a charter school is expected to have both a “District Test Coordinator (DTC)” AND a “School Test Coordinator”. Since a charter school typically has one (1) school, query whether it should have two (2) coordinators for one (1) school.

3. There are several sections that manifestly apply only to districts rather than districts and charter schools. See, e.g., §§2.2, 2.3, 4.4.1, 4.4.1.1, 4.4.2, 4.5.4, 4.6.1.1, 4.6.1.2, 4.6.2.1, and 4.6.2.2. The definition of “LEA” in §1.2 is somewhat cryptic but literally is limited to entities serving “a school district or combination of school districts”. This would exclude charter schools. See also 14 DE Admin Code 924, §9.0 (some, but not all, charter schools qualify as an LEA). In other sections, there are references which differentiate between districts and charters. See §§4.4.3, 10.1, 10.5.2.2, 10.5.2.3, and 12.1.1.2.

4. The regulation contemplates IDEA-eligible students in adult correctional facilities participating in the General Assessment and, potentially, alternate assessments. See §12.2.1.3. Since the DOE is responsible for serving such students, query whether the regulation adequately addresses whether there will be a “District Test Coordinator” or “School Test Coordinator” to cover incarcerated students.

5. Section 4.6.1.1 contains a “trigger” for a mandatory Department of Education review if a certain relative percentage of students participating in alternate assessments have good results (scoring Performance Level 3 or 4). This provides an incentive to depress student alternate assessment scores to avoid a DOE review/audit. The Department may wish to reconsider the merits of this approach.

6. In §12.1, the first “sentence” lacks a predicate/verb.

7. In §12.1.1.1, I suspect the Department meant to include a reference to “School Test Coordinator”. Compare §§12.1.1.2 and 12.1.1.2.1.

8. In §12.2, I believe the reference to “grades 2” should be “grades 3”. Compare §3.1.

9. In §12.2.2, second sentence, the reference to “physician” is too narrow. Compare 14 DE Admin Code 815, §1.0, definition of “healthcare provider”. This term is used in multiple DOE regulations. See, e.g., 14 DE Admin Code 805, §2.1.1. Cf. 14 DE Admin Code 930, §2.2 (referring to physician, advanced practice nurse, and physician assistant).

10. In §12.2.2.2, second sentence, I believe the reference to “School State Assessment Coordinator” should be converted to “School Test Coordinator”.

I recommend sharing the above observations with the DOE, SBE, and Lt. Governor’s Office.

#### 4. DOE Prop. Eligibility & IEP Reading Interventions Reg. [18 DE Reg. 281 (10/1/14)]

The Department of Education proposes to adopt some discrete changes to its IEP standards to implement S.B. No. 229 which was enacted in the summer of 2014. Background on S.B. No. 229 is contained in the attached August 26, 2014 News Journal article.

I have the following observations.

First, the DOE is proposing a few edits to eligibility standards. See §§6.11 and 6.12.4. The change to §6.12.4 is problematic:

6.12.4 Age of Eligibility: The age of eligibility of children identified as under Moderate Intellectual Disability and Severe Intellectual Disability Categories shall be from the third birthday through ~~20 years, inclusive~~ 21 years of age.

The revision is inconsistent with statutory law:

(1) “Child” means a person of 3 years of age, or an earlier age if otherwise provided in this title, until the receipt of a regular high school diploma or the end of the school year in which the person attains the age of 21, whichever occurs first.

Title 14 Del.C. §3101. All of the DOE eligibility regulations incorporate the statutory standard for termination of eligibility. See, e.g. 14 DE Admin Code 925, §§6.6.3, 6.13.5, and 6.17.5. The standard is also reinforced in 14 DE Admin Code 925, §6.5.4:

6.5.4. Exit Criteria: A child's eligibility for special education and related services shall terminate when:

6.5.4.1 the child reaches his or her 21<sup>st</sup> birthday. A child with a disability who reaches his or her 21<sup>st</sup> birthday after August 31 may continue to receive special education and related services until the end of the school year, including appropriate summer services through August 31; or

6.5.4.2 the child graduates from high school with a regular high school diploma. As used in this subsection, regular high school diploma does not include a GED;...

Based on the above analysis, the proposed regulation should be amended as follows:

6.12.4 Age of Eligibility: The age of eligibility of children identified as under Moderate Intellectual Disability and Severe Intellectual Disability Categories shall be from the third birthday through ~~20 years, inclusive~~ **[21 years of age until the receipt of a regular high school diploma or the end of the school year in which the student attains the age of twenty-one (21), whichever occurs first.**

Second, §24.0 is being revised to add the following considerations when developing an IEP:

24.2.7. In the case of any child with limited reading proficiency, consider the reading services, supports and evidenced based interventions as those relate to the child's IEP;

24.2.7.1. For a child who is not beginning to read by age seven, or who is beyond age seven and is not yet beginning to read, enumerate the specific, evidence-based interventions that are being provided to that child to address the child's inability to read.

This language is generally consistent with H.B. No. 229. However, it would be highly preferable to also include a reference to "prompt" the IEP team to address ESY as contemplated by H.B. No. 229. I recommend adoption of the following standard:

24.2.7. In the case of any child with limited reading proficiency, consider the reading services, supports and evidenced based interventions as those relate to the child's IEP;

24.2.7.1. For a child who is not beginning to read by age seven, or who is beyond age seven and is not yet beginning to read, the IEP shall:

24.2.7.1. Enumerate the specific, evidence-based interventions that are being provided to that child to address the child's inability to read; and

24.2.7.2. Provide for evidence-based interventions through extended school services (ESY) absent a specific explanation in the IEP why such services are inappropriate.

The omission of the above §24.2.7.2 from the proposed regulation is extremely problematic since it is not “captured” by any other DOE regulation and is explicitly required by H.B. No. 229. The effect is that IEP teams (and parents) will be unaware of the presumption that interventions be provided during the summer unless the contrary rationale is documented in the IEP. It is logical to include this provision within §24.0. Compare §24.2.3 (IEP must provide for Braille instruction unless IEP team determines Braille inappropriate).

I recommend sharing the above observations with the DOE, SBE, and Lt. Governor’s Office. The Councils may also wish to share a courtesy copy of comments with at least some of the sponsors of S.B. No. 229.

5. DOE Prop. Extended School Year Services Regulation [18 DE Reg. 280 (10/1/14)]

The Department of Education proposes to amend its extended school year (ESY) regulation to implement S.B. No. 229. S.B. No. 229 amended Title 14 Del.C. §3110 by adding the following mandate:

(e) With respect to any child with a disability who is not beginning to read by age seven, each IEP prepared for such student until that student is beginning to read shall (a) enumerate the specific, evidence-based interventions that are being provided to that student to address the student’s inability to read, and (b) provide for evidence-based interventions through extended school year services during the summer absent a specific explanation in the IEP as to why such services are inappropriate.

The attached August 26, 2014 News Journal article offers the following perspective on the new law from its co-author, the Lieutenant Governor:

This fall, a new law that helps elementary school students with disabilities will also take effect. The law, which I was proud to help author, helps elementary school students with disabilities who have reached age 7 but have not yet started to read. We know reading is critical to every facet of student success, but many of the students we wrote this law for have dyslexia or other diagnosable conditions that make it harder for them to decode written texts. There are evidence-based programs that have proven very successful at helping young students with decoding-related disabilities learn to read, but not all of our schools are providing young students with prompt access to these programs.

Under the newly enacted state law, every Individualized Education Plan for a student with a disability - who is not reading by age 7 - must state the specific, evidence-based interventions that are being provided to that student to address his or her reading skills. Just as importantly, each IEP for such students must provide for extra reading help over the summer, unless the IEP team explains why such help is not appropriate.

I encourage parents of students with disabilities who are not reading by age 7 to take full advantage of this new law. Ask for an IEP meeting if one is not already scheduled, and at that meeting, ask: “What are the evidence-based interventions that you are using to help my child learn to read,” “What is the evidence supporting this program” and “What summer interventions will we be using to help my child learn to read?” ...

In pertinent part, the DOE proposes to implement the new law with the following regulation:

6.5.4 Reading acquisition: For a child who is not beginning to read by age seven, or who is beyond age seven and not yet beginning to read, the team should determine whether, without extended school year services, appropriate and meaningful progress on IEP goal(s) related to reading will not be achieved.

The regulation represents a grudging, anemic attempt to fulfill the statute. First, while the statute creates a presumption that ESY will be offered to a non-reading student, the regulation simply promotes some vague consideration of ESY when reviewing progress on reading goals. Second, the regulation omits the requirement that the ESY interventions be “evidence-based” and targeted to reading. Third, the regulation omits the requirement that declining to include ESY in the IEP is disallowed unless the team includes “a specific explanation in the IEP as to why such services are inappropriate.”

I recommend adoption of the following substitute regulation:

6.5.4 Reading acquisition: For a child who is not beginning to read by age seven, or who is beyond age seven and not yet beginning to read, the team shall presumptively include extended school year services in the IEP which incorporate evidence-based interventions that address the child’s inability to read. The team may decline to include such extended school year services in the IEP only if the team provides a specific explanation in the IEP why such services are inappropriate.

This version of the regulation comports with both the letter and spirit of the enabling legislation.

Parenthetically, the Councils may wish to consult a reading specialist to assess the DOE’s proposed definition of “beginning to read”:

6.5.4.1. For purposes of the extended school year services (ESY) determination, a child is beginning to read if the child demonstrates phonological awareness and ability to use letter sound knowledge and decode unknown words.

Since the DOE recites that it is accepting comments through December 1, 2014, the Councils have some time to solicit an expert opinion on the proposed standard.

I recommend sharing observations and recommendations with the DOE, SBE, the Lt. Governor’s Office. The Councils may also wish to consider sharing comments with some co-sponsors of S.B. No. 229.



## 6. DOE Mechanical Restraint & Seclusion Waiver Application & Review Guidance (1014)

S.B. No. 100, enacted in 2013, bans use of mechanical restraint or seclusion in public schools in the absence of a waiver. The Department of Education recently adopted implementing regulations. See 18 DE Reg. 130 (August 1, 2014). The DOE has published two attached follow-up documents on its website which were shared with the DDC on September 30: 1) form captioned “Request for Individual Student Waiver for Mechanical Restraint(s) or Seclusion”; and 2) guidance captioned “Considerations for Recommendations Related to Waiver Requests for Restraint and Seclusion”.

I have the following observations on the documents.

### Waiver Request Form

A. The form categorically assumes that all students for whom a waiver is requested will be IDEA-identified. There may be students who are not IDEA-identified who manifest extreme behaviors which could prompt a waiver request. Therefore, the form could be modified to ask if the student is IDEA-identified or §504-identified. The latter information may also assist with reporting data to OCR.

B. The “Student Health” section includes the following inquiry: “Does the student have any medical conditions that impact and/or contribute to their performance of problem behavior?” This is somewhat difficult to interpret. I assume the inquiry is intended to elicit information about conditions such as ADHD or TBI which could contribute to problematic behavior. The DOE could consider adding a clarifying example. Parenthetically, I also recommend substituting “the student’s” for “their” to obviate use of a plural pronoun (“their”) with a singular antecedent (“student”).

C. The “Student Health” section should be embellished to include medical “contraindications” for use of mechanical restraint or seclusion. For example, if a student has an orthopedic or other physical (e.g. brittle bone) disability, medical clearance should be required prior to authorizing use of a mechanical restraint. Similarly, if a child has been abused in the past by being locked in a closet, a psychiatrist may oppose use of seclusion for clinical reasons. Compare 14 Del.C. §4112F(b)(2)d (use of physical restraint may not exacerbate medical or physical condition of student).

D. The DOE regulation [14 DE Admin Code 610, §8.3.4] authorizes the DOE to approve a waiver for a period not to exceed one calendar year. An applicant may wish to only seek a waiver for a short period (e.g. 2-3 months) as a pilot or assessment to determine the efficacy of the intervention. The form could be amended by including a field for requested time period for the waiver.

E. In the “Problem Behavior” section, it may be clearer to substitute “”for which the waiver is being requested” for “for which the action is being requested”.

F. In “Description of Behavior Plan”, Par. 6 recites as follows: “Is there an intervention that describes how others will respond after the problem behavior so that it no longer provides reinforcement/functional outcome?” The reference to “functional” is counterintuitive. The intervention should be designed to no longer provide a disfavored, “dysfunctional” outcome, not a “functional” outcome.

G. In the “Data” section, the following reference makes no sense: “1. Was implementation fidelity collected?” Perhaps DOE intended to say “(w)as data/information related to implementation fidelity collected?”

H. I recommend changing the “Restraint/Seclusion” section heading to “Mechanical Restraint/Seclusion”. In the same section, requesting data from “the most recent school year” may be uninformative if the waiver request is filed near the beginning of the school year. Consider requiring data for the current school year or past 9 months, whichever is longer.

I. The “Restraint/Seclusion” section is odd because it requests information on frequency of usage of mechanical restraint or seclusion when such interventions are banned in the absence of the waiver. The DOE may wish to consider two amendments. First, data on the use of physical restraint and time-out should be specifically solicited. The frequency and duration of use of physical restraint and time-out could be very helpful data informing the DOE’s review. If time-out is effective, or has not been attempted, there may be little need to approve seclusion. Second, if data on mechanical restraint/seclusion is requested, the heading should reflect that the inquiry applies to requests for waiver renewal. Otherwise, schools may be misled into believing they must have baseline data on mechanical restraint and seclusion as a precondition of requesting a waiver.

J. In the “documentation” section, I recommend adding “§504 plan”.

#### Guidance: Waiver Review Considerations

A. In the title, I recommend inserting “Mechanical” prior to “Restraint”.

B. The guidance should be amended to include consideration of any matters added to the form based on the above recommendations (e.g. medical contraindications; physical restraint and time-out data).

C. “Consideration 2” envisions assessing data on use of mechanical restraint/seclusion prior to approval of the waiver. In general, there should be no such data since these interventions are banned in the absence of the waiver. The DOE could amend this section to clarify that it only applies to requests for waiver renewal.

D. It would be preferable to address the time period for the approved waiver. The DOE should not simply grant a 1-year waiver in all cases.

E. In "Consideration 5", I recommend deleting "naive person (to the plan)" and substituting "person unfamiliar with the plan". This is the language used in the "Request" form, Description of Behavior Plan, Par. 6.

F. The guidance document fails to prompt consideration of "specific conditions and safeguards...and reasons therefore" consistent with §8.3.2 of the regulations and 14 Del.C. §4112F( c)(4). For example, the DOE review committee could restrict seclusion to a certain duration or type of room. Without a "prompt", the committee could overlook this part of the assessment.

G. Section 8.3.4 of the regulations allows the DOE to make its waiver approval contingent upon the applicant's collection of specific data. The guidance should include a "prompt" so the DOE review committee considers the types and frequency of data it will require.

H. The guidance document would benefit from mentioning the overall statutory and regulatory standard for granting a waiver, i.e., "compelling justification". The burden is on the applicant to produce very convincing documentation of need. The review is not intended to be "pro forma" or result in "routine" approval based on borderline justification.

I recommend sharing the above observations and recommendations with the Department.

#### Attachments

E:\legreg\1014bils  
F:\pub\bjh\legis\2014p&l\1014bils



STATE OF DELAWARE  
STATE COUNCIL FOR PERSONS WITH DISABILITIES

MARGARET M. O'NEILL BUILDING  
410 FEDERAL STREET, SUITE 1  
DOVER, DE 19901

VOICE: (302) 739-3620  
TTY/TDD: (302) 739-3699  
FAX: (302) 739-6704

MEMORANDUM

DATE: August 28, 2014

TO: Ms. Sharon L. Summers, DMMA  
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson  
*DM-P/25*  
State Council for Persons with Disabilities

RE: 18 DE Reg. 106 [DMMA Proposed PASRR Regulation (8/1/14)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to amend the Medicaid State Plan regarding administration of Medicaid Preadmission Screening and Resident Review (PASRR). The proposed regulation was published as 18 DE Reg. 106 in the August 1, 2014 issue of the Register of Regulations.

Consistent with the "Background" section in the Register of Regulations, federal law was adopted decades ago to prevent the inappropriate placement of individuals with mental illness or intellectual disabilities in nursing facilities. States are required to conduct an initial Level 1 screening to determine if an applicant for nursing facility admission may have a mental illness or intellectual/developmental disability. If that screening supports the existence of a mental illness or intellectual disability, a Level II screening is undertaken which results in a determination of need, appropriate setting, and identification of any "specialized services" if the individual is admitted to the nursing facility. States are authorized to adopt a "short cut" to the Level II screening if certain criteria are met. Such "categorical determinations" may be based on certain diagnoses, severity of illness, or brevity of anticipated stay.

There are two (2) main features in the proposed regulation. First, DMMA is identifying seven (7) qualifiers for a "categorical determination": 1) convalescent care; 2) terminal illness; 3) medical dependence; 4) delirium; 5) emergency situations; 6) respite; and 7) dementia combined with intellectual disability. Second, DMMA is defining each of these qualifiers.

SCPD has the following observations.

First, at the top of page 112, the definition of “convalescent care” may have omitted a word. It recites as follows:

X. Convalescent Care: NF services are needed for from an acute physical illness which required hospitalization, and does not meet all the criteria for an exempt hospital discharge.

The serial prepositions (for from) are grammatically odd. SCPD suspects the term should be “for or from” an acute physical illness. DMMA may wish to review this sentence.

Second, in the past, there was considerable discussion of which agency issues the final PASRR decision. See, e.g., 15 DE Reg. 86, 88, “Seventh” Paragraph (July 1, 2011). The proposed regulation would benefit from a clarifying amendment to avoid confusion. There is some “tension” between the recital that DSAMH/DDDS adopt “the final determination” versus the recital that DMMA issues the final determination. See Pars. 9 and 10 at p. 115. For example, Par. 9 could be revised as follows:

9. DSAMH/DDDS notifies DMMA of the agency’s Level II Evaluation determination.

Third, it may not be intuitive that the final DMMA PASRR is appealable to DSS. See 16 DE Admin Code 5001, Subsection 2.D; 5304; 5304.1; and 5401, Subsection 1.C.4. DMMA could consider amending Par. 10 on p. 115 as follows:

10. Final PASRR determinations will be issued by DMMA and are subject to 16 DE Admin Code 5000.

Fourth, DMMA and DSS may wish to review 16 DE Admin Code 5304.1 which reads as follows:

Individuals adversely affected by determinations made by the Division of Substance Abuse and Mental Health (DSAMH) or the Division of Developmental Disabilities Services (DDDS) as a result of a pre-admission screening resident review PASRR may appeal the decision to the Division of Social Services (DSS). The hearing is conducted by DSS and the decision is binding on the Department of Health and Social Services. ... Final PASRR determinations will be issued by DMMA.

There is some “tension” between the notion that DMMA issues the final PASRR determination but the decision subject to hearing is the DSAMH or DDDS determination. DMMA may wish to consider whether this regulation merits prospective modification.

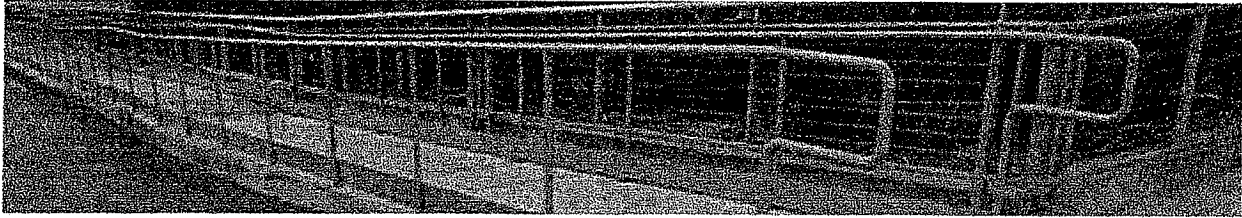
Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: The Honorable Rita Landgraf  
Mr. Stephen Groff  
Ms. Elaine Archangelo  
Ms. Deborah Gottschalk  
Mr. Brian Hartman, Esq.  
Governor's Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

18reg106 dmma PASRR 8-28-14

ADA Ramp

PRINT



ADA Ramp

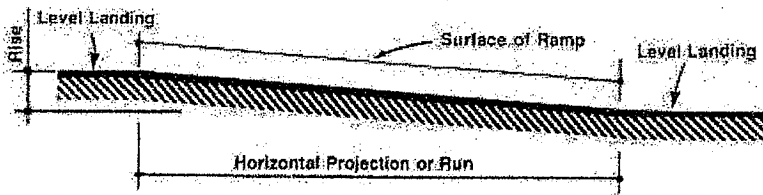
4.8 Ramps

4.8.1\* General

Any part of an accessible route with a slope greater than 1:20 shall be considered a ramp and shall comply with 4.8.

4.8.2\* Slope and Rise

The least possible slope shall be used for any ramp. The maximum slope of a ramp in new construction shall be 1:12. The maximum rise for any run shall be 30 in (760 mm). Curb ramps and ramps to be constructed on existing sites or in existing buildings or facilities may have slopes and rises as allowed in 4.1.6(3)(a) if space limitations prohibit the use of a 1:12 slope or less.



Slope	Maximum Rise		Maximum Horizontal Projection	
	in	mm	ft	in
1:12 to < 1:16	30	760	30	9
1:16 to < 1:20	30	760	40	12

4.8.3 Clear Width.

The minimum clear width of a ramp shall be 36 in (915 mm).

**4.8.4\* Landings**

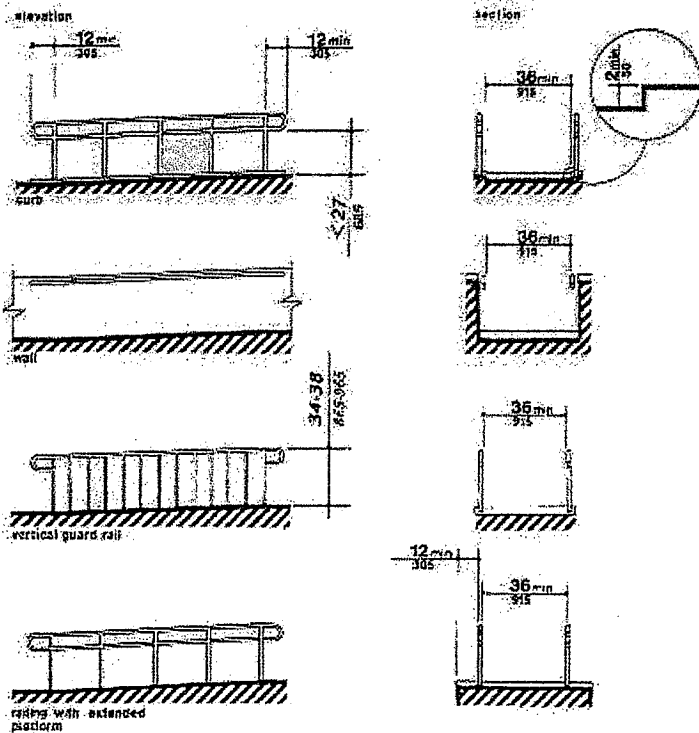
Ramps shall have level landings at bottom and top of each ramp and each ramp run. Landings shall have the following features:

- (1) The landing shall be at least as wide as the ramp run leading to it.
- (2) The landing length shall be a minimum of 60 in (1525 mm) clear.
- (3) If ramps change direction at landings, the minimum landing size shall be 60 in by 60 in (1525 mm by 1525 mm).
- (4) If a doorway is located at a landing, then the area in front of the doorway shall comply with 4.13.6.

**4.8.5\* Handrails**

If a ramp run has a rise greater than 6 in (150 mm) or a horizontal projection greater than 72 in (1830 mm), then it shall have handrails on both sides. Handrails are not required on curb ramps or adjacent to seating in assembly areas. Handrails shall comply with 4.26 and shall have the following features:

- (1) Handrails shall be provided along both sides of ramp segments. The inside handrail on switchback or dogleg ramps shall always be continuous.
- (2) If handrails are not continuous, they shall extend at least 12 in (305 mm) beyond the top and bottom of the ramp segment and shall be parallel with the floor or ground surface.





- (3) The clear space between the handrail and the wall shall be 1 - 1/2 in (38 mm).
- (4) Gripping surfaces shall be continuous.
- (5) Top of handrail gripping surfaces shall be mounted between 34 in and 38 in (865 mm and 965 mm) above ramp surfaces.
- (6) Ends of handrails shall be either rounded or returned smoothly to floor, wall, or post.
- (7) Handrails shall not rotate within their fittings.

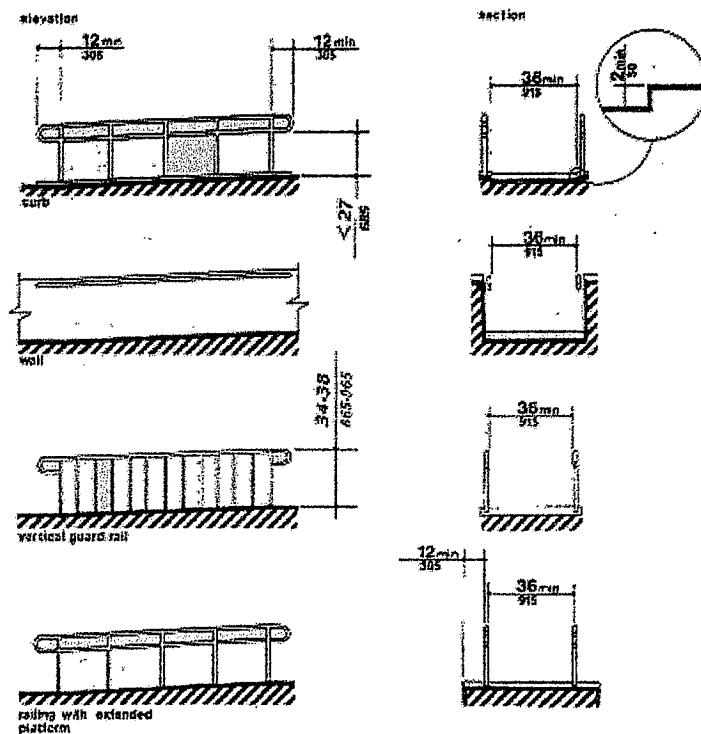
**4.8.6 Cross Slope and Surfaces**

The cross slope of ramp surfaces shall be no greater than 1:50. Ramp surfaces shall comply with 4.5.

**4.8.7 Edge Protection**

Ramps and landings with drop-offs shall have curbs, walls, railings, or projecting surfaces that prevent people from slipping off the ramp. Curbs shall be a minimum of 2 in (50 mm) high.

**Examples of Edge Protection and Handrail Extensions**



**Examples of Edge Protection and Handrail Extensions.**

Four types of edge protection and handrail design are shown. The first ramp (top) labeled "Curb" shows a handrail horizontal projection of 12 inches (305 mm) minimum at the top and bottom of the ramp. The horizontal projection begins at the point where the sloped ramp surface stops. Edge protection on both sides of the ramp is a raised surface at least 2 inches (50 mm) high. A minimum clear width of 36 inches (915 mm) is provided between handrails and the edge protection. A lower railing is shown parallel to the ramp mounted no higher than 27 inches (685 mm) above the ramp.

The second ramp (second from top) labeled "Wall" shows a railing mounted on a solid wall. The handrails on both sides have horizontal projections as above. A minimum of 36 inches (915 mm) is provided between handrails.

The third ramp (third from top) labeled "Vertical Guard Rail" has a series of vertical guard rails or pickets. The top of the handrail is shown as 34 - 38 inches (865 mm - 965 mm) above the ramp and landings (applies to all handrails on accessible ramps). A minimum of 36 inches (915 mm) is provided between handrails.

The fourth ramp (fourth from top) labeled "Railing with Extended Platform" shows a railing without edge protection on the ramp surface. The ramp surface extends a minimum of 12 inches (305 mm) to the side of the handrail. The handrail detail is the same as the first example with a bottom rail no more than 27 inches (305 mm) above the ramp and landings. A minimum of 36 inches (915 mm) is provided between handrails.

#### **4.8.8 Outdoor Conditions**

Outdoor ramps and their approaches shall be designed so that water will not accumulate on walking surfaces.




---

## Frequently Asked Questions about *Clostridium difficile* for Healthcare Providers

---

### On this Page

- [What is \*Clostridium difficile\*? \(#a1\)](#)
- [What diseases result from \*Clostridium difficile\* infection? \(#a2\)](#)
- [What are the main clinical symptoms of \*Clostridium difficile\* infection? \(#a3\)](#)
- [Which patients are at increased risk for \*Clostridium difficile\* infection? \(#a4\)](#)
- [What are the differences between \*Clostridium difficile\* colonization and \*Clostridium difficile\* infection? \(#a6\)](#)
- [Which laboratory tests are commonly used to diagnose \*Clostridium difficile\* infection? \(#a7\)](#)
- [How is \*Clostridium difficile\* transmitted? \(#a8\)](#)
- [How is \*Clostridium difficile\* infection usually treated? \(#a9\)](#)
- [How can \*Clostridium difficile\* infection be prevented in hospitals and other healthcare settings? \(#a10\)](#)
- [What can I use to clean and disinfect surfaces and devices to help control \*Clostridium difficile\*? \(#a11\)](#)
- [How has \*Clostridium difficile\* \(\*C. difficile\*\) infections \(CDI\) changed? \(#changed\)](#)
- [How is the epidemic strain detected? \(#detected\)](#)
- [Is treatment of this epidemic strain different? \(#different\)](#)
- [How does fluoroquinolone resistance affect management of this strain? \(#fr\)](#)
- [What should healthcare facilities do in response to the emergence of the epidemic strain? \(#emergence\)](#)
- [Where can I get more information? \(#a12\)](#)

### What is *Clostridium difficile*?

*Clostridium difficile* is a spore-forming, Gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD). It accounts for 15-25% of all episodes of AAD.

### What diseases result from *Clostridium difficile* infection?

- pseudomembranous colitis (PMC)
- toxic megacolon
- perforations of the colon
- sepsis
- death (rarely)

### What are the main clinical symptoms of *Clostridium difficile* infection?

Clinical symptoms include:

- watery diarrhea
- fever
- loss of appetite
- nausea
- abdominal pain/tenderness

## Which patients are at increased risk for *Clostridium difficile* infection?

The risk for disease increases in patients with:

- antibiotic exposure
- proton pump inhibitors
- gastrointestinal surgery/manipulation
- long length of stay in healthcare settings
- a serious underlying illness
- immunocompromising conditions
- advanced age

## What are the differences between *Clostridium difficile* colonization and *Clostridium difficile* infection?

### *Clostridium difficile* colonization

- patient exhibits NO clinical symptoms
- patient tests positive for *Clostridium difficile* organism and/or its toxin
- more common than *Clostridium difficile* infection

### *Clostridium difficile* infection

- patient exhibits clinical symptoms
- patient tests positive for the *Clostridium difficile* organism and/or its toxin

## Which laboratory tests are commonly used to diagnose *Clostridium difficile* infection?

- Stool culture for *Clostridium difficile*: While this is the most sensitive test available, it is the one most often associated with false-positive results due to presence nontoxigenic *Clostridium difficile* strains. However, this can be overcome by testing isolates for toxin production (i.e. so called “toxigenic culture”). Nonetheless, stool cultures for *Clostridium difficile* are labor intensive, require an appropriate culture environment to grow anaerobic microorganisms, and have a relatively slow turn-around time (i.e. results available in 48-96 hours) making them overall less clinically useful. Results of toxigenic cultures do serve as a gold-standard against which other test modalities are compared in clinical trials of performance.
- Molecular tests: FDA-approved PCR assays, which test for the gene encoding toxin B, are highly sensitive and specific for the presence of a toxin-producing *Clostridium difficile* organism.
- Antigen detection for *Clostridium difficile*: These are rapid tests (<1 hr) that detect the presence of *Clostridium difficile* antigen by latex agglutination or immunochromatographic assays. Because results of antigen testing alone are non-specific,

antigen assays have been employed in combination with tests for toxin detection, PCR, or toxigenic culture in two-step testing algorithms.

- Toxin testing for *Clostridium difficile*:
  - Tissue culture cytotoxicity assay detects toxin B only. This assay requires technical expertise to perform, is costly, and requires 24-48 hr for a final result. It does provide specific and sensitive results for *Clostridium difficile* infection. While it served as a historical gold standard for diagnosing clinical significant disease caused by *Clostridium difficile*, it is recognized as less sensitive than PCR or toxigenic culture for detecting the organism in patients with diarrhea.
  - Enzyme immunoassay detects toxin A, toxin B, or both A and B. Due to concerns overtaking A-negative, B-positive strains causing disease, most laboratories employ a toxin B-only or A and B assay. Because these are same-day assays that are relatively inexpensive and easy to perform, they are popular with clinical laboratories. However, there are increasing concerns about their relative insensitivity (less than tissue culture cytotoxicity and much less than PCR or toxigenic culture).
- *Clostridium difficile* toxin is very unstable. The toxin degrades at room temperature and may be undetectable within 2 hours after collection of a stool specimen. False-negative results occur when specimens are not promptly tested or kept refrigerated until testing can be done.

## How is *Clostridium difficile* transmitted?

*Clostridium difficile* is shed in feces. Any surface, device, or material (e.g., commodes, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the *Clostridium difficile* spores. *Clostridium difficile* spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item.

## How is *Clostridium difficile* infection usually treated?


In about 20% of patients, *Clostridium difficile* infection will resolve within 2-3 days of discontinuing the antibiotic to which the patient was previously exposed. The infection can usually be treated with an appropriate course (about 10 days) of antibiotics, including metronidazole, vancomycin (administered orally), or recently approved fidaxomicin. After treatment, repeat *Clostridium difficile* testing is not recommended if the patients' symptoms have resolved, as patients may remain colonized.

## How can *Clostridium difficile* infection be prevented in hospitals and other healthcare settings?

- Use antibiotics judiciously
- Use Contact Precautions: for patients with known or suspected *Clostridium difficile* infection:
  - Place these patients in private rooms. If private rooms are not available, these patients can be placed in rooms (cohorted) with other patients with *Clostridium difficile* infection.
  - Use gloves when entering patients' rooms and during patient care.
  - Perform Hand Hygiene after removing gloves.
    - Because alcohol does not kill *Clostridium difficile* spores, use of soap and water is more efficacious than alcohol-based hand rubs. However, early experimental data suggest that, even using soap and water, the removal of *C. difficile* spores is more challenging than the removal or inactivation of other common pathogens.

- Preventing contamination of the hands via glove use remains the cornerstone for preventing *Clostridium difficile* transmission via the hands of healthcare workers; any theoretical benefit from instituting soap and water must be balanced against the potential for decreased compliance resulting from a more complex hand hygiene message.
- If your institution experiences an outbreak, consider using only soap and water for hand hygiene when caring for patients with *Clostridium difficile* infection.
- Use gowns when entering patients' rooms and during patient care.
- Dedicate or perform cleaning of any shared medical equipment.
- Continue these precautions until diarrhea ceases.
  - Because *Clostridium difficile*-infected patients continue to shed organism for a number of days following cessation of diarrhea, some institutions routinely continue isolation for either several days beyond symptom resolution or until discharge, depending upon the type of setting and average length of stay.
- Implement an environmental cleaning and disinfection strategy:
  - Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently.
  - Consider using an Environmental Protection Agency (EPA)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions; generic sources of hypochlorite (e.g., household chlorine bleach) also may be appropriately diluted and used. (Note: Standard EPA-registered hospital disinfectants are not effective against *Clostridium difficile* spores.) Hypochlorite-based disinfectants may be most effective in preventing *Clostridium difficile* transmission in units with high endemic rates of *Clostridium difficile* infection.
  - Follow the manufacturer's instructions for disinfection of endoscopes and other devices.
- Recommended infection control practices in long term care and home health settings are similar to those practices taken in traditional health-care settings.

## What can I use to clean and disinfect surfaces and devices to help control *Clostridium difficile*?

Surfaces should be kept clean, and body substance spills should be managed promptly as outlined in CDC's "[Guidelines for Environmental Infection Control in Health-Care Facilities.](#)"  [PDF 1.4 MB] ([/hcupac/pdf/guidelines/eic\\_in\\_HCF\\_o3.pdf](/hcupac/pdf/guidelines/eic_in_HCF_o3.pdf)) Routine cleaning should be performed prior to disinfection. EPA-registered disinfectants with a sporicidal claim have been used with success for environmental surface disinfection in those patient-care areas where surveillance and epidemiology indicate ongoing transmission of *Clostridium difficile*. **Note:** EPA-registered disinfectants are recommended for use in patient-care areas. When choosing a disinfectant, check product labels for inactivation claims, indications for use, and instructions.

## How has *Clostridium difficile* (*C. difficile*) infections (CDI) changed?

Over the past several years nationwide, states have reported increased rates of *C. difficile* infection, noting more severe disease and an associated increase in mortality. *C. diff* infection remains a disease mostly associated with healthcare (at least 80%) Patients most at risk remain the elderly, especially those using antibiotics. Although the elderly are still most affected, more disease has been reported in traditionally 'low risk' persons such as healthy persons in the

community, and peripartum women. These changes may be largely due to the new emergence of the current epidemic strain of *C. difficile*, known by its names assigned by various typing schemes as restriction enzyme analysis type BI, North American Pulsed Field type 1 (NAP1), or PCR ribotype 027. BI/NAP1/027 has spread widely after first being found responsible for outbreaks in Pittsburgh (2000), Atlanta (2001-2), and Montreal (2003). This strain appears more virulent possibly due to its increased production of toxins A and B and its production of an additional toxin known as binary toxin, as well as other factors still under study. In addition to being more virulent, it is more resistant to a commonly-used class of antimicrobials known as the fluoroquinolones. Additional information about this strain and how it has changed the face of *C. diff* infection see [Bench-to-bedside review: Clostridium difficile colitis](#) [PDF - 198 KB] ([/HAI/pdfs/cdiff/Gould\\_CritCare2008.pdf](#)).

## How is the epidemic strain detected?

Like other strains of *C. difficile*, BI/NAP1/027 can be detected in the stool of infected patients by using laboratory tests that are commonly available in most hospitals. However, none of the FDA-approved tests differentiate between the various strains of *C. difficile*. Fortunately, because the control measures for outbreaks of any strain of *C. difficile* are similar, identification of the specific strain is not imperative for controlling outbreaks.

## Is treatment of BI/NAP1/027 different?

The usual treatment for *C. difficile* infection includes, if possible, stopping antibiotics being given for other purposes and/or treatment with metronidazole or vancomycin. In order to reduce selective pressure for vancomycin resistance in enterococci, current guidelines recommend the first-line use of metronidazole over vancomycin.

Recent reports suggest that BI/NAP1/027 may not respond as well to treatment with metronidazole despite the absence of laboratory evidence of metronidazole resistance. Evidence suggests that more severe disease should be treated with vancomycin, over metronidazole.

## How does fluoroquinolone resistance affect management of BI/NAP1/027?

Increased fluoroquinolone resistance does not affect the management of infections caused by this strain. Fluoroquinolones have never been recommended for treatment of *C. difficile* infection and susceptibility testing is performed only as a part of an epidemiological investigation. However, resistance to fluoroquinolones may provide the new strain with an advantage over susceptible strains to spread within healthcare facilities where these antibiotics are commonly used.

## What should healthcare facilities do in response to the emergence of the BI/NAP1/027?

Healthcare facilities should monitor the number of *C. difficile* infections and, especially if rates at the facility increase, the severity of disease and patient outcomes. If an increase in rates or severity is observed, healthcare facilities should reassess compliance with core recommended practices as outlined in the [CDC Toolkit for Evaluation of Environmental Cleaning](#) [PDF - 1.05 MB] ([/HAI/pdfs/toolkits/CDItoolkitwhite\\_clearance\\_edits.pdf](#)), for known cases of *C. diff* infection including the following:

If compliance appears high to core recommendations, consideration should be made to implement supplemental recommendations as described in the toolkit. If assistance is needed with these measures, additional help should be sought from local or state health departments and/or local infection control experts.

## Where can I get more information?

The Centers for Disease Control and Prevention also has [General Information about \*Clostridium difficile\*.](#) (</hai/organisms/cdiff/Cdiff-patient.html#gen>)

---

Page last reviewed: November 25, 2010

Page last updated: March 6, 2012

Content source: [Centers for Disease Control and Prevention](#)

[National Center for Emerging and Zoonotic Infectious Diseases \(NCEZID\)](#)

[Division of Healthcare Quality Promotion \(DHQP\)](#)

---

Centers for Disease Control and Prevention 1600 Clifton Road Atlanta, GA  
30329-4027, USA  
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - [Contact CDC-INFO](#)





# Bill seeks choice in special needs assessments

Lawmaker wants life skills to take priority over set benchmarks

By **Matthew Albright**  
The News Journal

Parents of students with severe learning disabilities could choose to have them assessed at the end of the year without taking a test, if a proposal in the legislature becomes law.

Some 1,200 special needs students currently take an alternative version of the Delaware Comprehensive Assessment System called the DCAS Alt-1.

Instead of the traditional testing model, those students work with educators who do things like read them stories, show them pictures or help them do math problems, measuring their understanding as they go.

Sen. Nicole Poore, D-New Castle, wants parents, working with officials at their school, to be able to forego that alternative assessment in favor of a "portfolio model," that sets goals for skills students should have by the end of the year.

Poore said students, including her son, have disabilities that make daily living difficult, so schools should be fo-



Sen. Nicole Poore

cused on teaching them skills that improve their quality of life rather than measuring academic benchmarks.

"Tell me what value the state of Delaware gets for testing my child and knowing he isn't meeting the standards in social studies or math?" Poore asked. "What does anyone get out of that?"

Instead, Poore would like to see students measured on life skills. Her son, for example, loves computers, so parents could work with school staff to develop an assessment for typing sentences.

"I'm not saying that children shouldn't have some type of expectations. And if parents want to continue using Alt-1, we certainly don't want to stop them," she said. "What I'm saying is, as parents, we should be the ones that are guiding those expectations."

The bill, SB 229, has passed the Senate with two amendments, and now heads to the House.

Department of Education officials say the state needs to be careful not to run afoul of federal rules such as those in the Individuals with Disabilities Education Act. They have worked with Poore to amend the bill, and say some more tweaks may be necessary.

"The version that passed the Senate is better, and we're committed to working with the sponsors to further clarify it," said Mary Kate McLaughlin, the department's chief of staff.

"We believe that we have an effective alternative assessment, but we're hearing through the dialogue that this bill has

created that there are parents who would prefer another option on top of that."

McLaughlin said it's unclear how many students of the 1,200 or so who take DCAS-I would be affected, since it would be up to parents and schools to choose the new system.

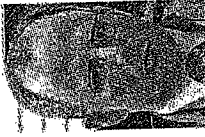
Some lawmakers worry the proposal could lower expectations for special-needs students.

"I understand Sen. Poore's intentions and I think they're noble. But I'm concerned, and I know others are concerned, that this could have unintended consequences," said Senate Minority Whip Greg Lavelle, R-Sharples.

"What we don't want to happen is for the accountability for these students to be lessened. We want every student in this state to have the expectation that they are going to grow."

Lavelle, who has a special-needs child himself, said he understands the difficulties they face in learning. But he worries the alternative assessment could be too broadly applied, leaving some students with less severe disabilities to go unchallenged academically.

He is also concerned about how the bill would play out in Individualized Education Plan teams, which work out the highly-technical legalistic process of determining what services special-needs students receive.



Sen. Greg Lavelle

"I've been through a lot of IEP meetings, and sometimes it feels like you're just sort of directing the horse where to go," Lavelle said.

"Frankly, it's a very difficult process to understand, and I worry that some parents may not be able to effectively advocate for their child's needs."

The debate comes as Delaware gears up for the Smarter Balanced Assessment, a new test aimed at measuring how well students stack up to the Common Core State Standards - new national expectations for what students should know and be able to do academically.

State officials say Smarter Balanced is a powerful new tool that can better figure out whether students have a cursory knowledge of a subject or have actually mastered it.

But the test is intentionally designed to be tougher, and some parent and teacher groups are concerned about the strain it could place on students and schools.

All told, the test could take eight and a half hours for juniors over several days, about twice as long as standard college admissions exams.

Plans for an alternative Smarter Balanced assessment are in the works, but education department officials say students with disabilities will continue to take DCAS Alt-1 for the time being.

Contact Matthew Albright at malbright@delawareonline.com or at (302) 324-2428. Follow him on Twitter @TNJ\_malbright.

# New school year, new opportunities for parents

DELAWARE VOICE: Lt. Gov. Matt Denn 4:15 p.m. EDT August 26, 2014



(Photo: SUBMITTED)

The beginning of the school year is an exciting time for all of us who have school-aged kids. I am privileged to visit schools on a regular basis and have the opportunity to hear from teachers and parents about what is working well and what could be improved when it comes to getting parents more involved in education. With the beginning of this school year, here are just a few things we've been working on in my office that might offer some assistance to those parents.

In the next few days, every public school in the state will receive an application for one of the state's Accelerated Academic Program grants. These grants, now in their second year, were created by legislation I wrote with several legislators to give public schools the opportunity to create new programs that would better challenge those students capable of doing schoolwork beyond their current grade level.

**LETTER:** [Demand tougher teacher standards \(/story/opinion/readers/2014/08/25/demand-tougher-teacher-standards/14418057/\)](#)

**LETTER:** [Kudos for parent responsibilities editorial \(/story/opinion/readers/2014/08/25/kudos-parent-responsibilities-editorial/14593661/\)](#)

Last fall, the first set of grants were awarded, and it has been exciting to see these schools using their grant money to create new programs incorporating math, reading, computers and the arts. I encourage parents to ask their schools and school districts to apply for these grants (applications are due by Oct. 1). Parents should not have to seek out specialized public schools or private schools in order to ensure their academically advanced children are receiving interesting, challenging coursework – students should be able to receive that work right in their home schools, and these grants start us down the road to making that possible.

This fall, a new law that helps elementary school students with disabilities, will also take effect. The law, which I was proud to help author, helps elementary school students with disabilities who have reached ages 7 but have not yet started to read. We know reading is critical to every facet of student success, but many of the students we wrote this law for have dyslexia or other diagnosable conditions that make it harder for them to decode written texts. There are evidence-based programs that have proven very successful at helping young students with decoding-related disabilities learn to read, but not all of our schools are providing young students with prompt access to these programs.

Under the newly enacted state law, every Individualized Education Plan for a student with a disability – who is not reading by age 7 – must state the specific, evidence-based interventions that are being provided to that student to address his or her reading skills. Just as importantly, each IEP for such students must provide for extra reading help over the summer, unless the IEP explains why such help is not appropriate.

I encourage parents of students with disabilities who are not reading by age 7 to take full advantage of this new law: Ask for an IEP meeting if one is not already scheduled, and at that meeting, ask: "What are the evidence-based interventions that you are using to help my child learn to read," "What is the evidence supporting this program" and "What summer interventions will we be using to help my child learn to read?" If you do not receive satisfactory answers, contact Kim Siegel ([kimsiegel@state.de.us](mailto:kimsiegel@state.de.us) (<mailto:kimsiegel@state.de.us>)) in my office and we will refer you to organizations that can help you.

Finally, in the coming few weeks, my office will be emailing every state school and PTA an electronic publication we just put together featuring the 10 schools that have won the Lieutenant Governor's "Excellence in Parental Involvement Award" over the past five years. We created this award in 2009 in order to highlight the importance of parental involvement on students' success and to shine a spotlight on innovative and successful programs taking place throughout the state that might serve as models for parents or teachers wishing to improve parental involvement in their own schools.

This publication contains detailed descriptions of the diverse programs that have been recognized. If you are a parent interested in expanding parental involvement in your school, I encourage you to visit my website for a copy (<http://ltgov.delaware.gov> (<http://ltgov.delaware.gov/>)).

I believe that the success of our schools depends in large part on efforts like these – challenging our academically advanced students, reaching out early and effectively to students who are struggling, and involving parents in a meaningful way. I encourage parents to seize the new opportunities in each of these areas that are available at the beginning of this school year, so that we can make this the best year ever for our state's kids.

Matt Denn is Delaware's Lieutenant Governor.

Read or Share this story: <http://delonline.us/1tGNZO8>



Therapeutic services (private)	Provider	Describe integration with school program
<b>Student Health</b>		
1. Date of most recent evaluation for disability eligibility		
2. Does the student have any medical conditions that impact and/or contribute to their performance of problem behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
3. What was the date of student's last medical exam?		
4. Date of last exams/screening for vision?		
5. Date of last exam/screening for hearing?		
6. Does the student take prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, please list below)
7. Are the medications taken regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. When the student does or does not take his/her medication is a difference in target behavior(s) observed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
<b>Parent/Guardian Information</b>		
Name:		Name:
Address (if different than student):		Address (if different than student):
Telephone:		Telephone:
Relationship to Student:		Relationship to Student:

I have reviewed all documents and received a copy of this request for a waiver for seclusion or mechanical restraint (as described below) to be used within my child's Behavior Intervention Plan, in the event my child is in ***imminent risk of bodily harm to self or others***. My signature authorizes my permission for this request. However, I understand that at any time, I can inform the school that I withdraw my permission.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

<b>Requesting Administrator</b>	Program/School	District:
Name:	Title:	
Email:	Telephone:	Fax:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other Administrators	Print Name	Signature	Date
Program Director			
Special Education			
Superintendent			

**Type of Waiver Requested:** *(check appropriate box)*

**“Mechanical restraint”** means the application of any device or object that restricts a student’s freedom of movement or normal access to a portion of the body that the student cannot easily remove. “Mechanical restraint” does not include devices or objects used by trained school personnel, or used by a student, for the specific and approved therapeutic or safety purposes for which they were designed and, if applicable, prescribed, including the following:

- Restraints for medical immobilization;
- Adaptive devices or mechanical supports used to allow greater freedom of movement, stability than would be possible without use of such devices or mechanical supports;
- Vehicle safety restraints when used as intended during the transport of a student in a moving vehicle;
- Instruction and use of restraints as part of a criminal justice or other course; or
- Notwithstanding their design for other purposes, adaptive use of benign devices or objects, including mittens and caps, to deter self-injury.

**“Seclusion”** means the involuntary confinement of a student alone in a room, enclosure, or space that is either locked or, while unlocked, physically disallows egress. The use of a “timeout” procedure during which a staff member remains accessible to the student shall not be considered “seclusion.” (Authority: 14 Del.C. §4112F(a)(5))

**Detailed Description of Each Proposed Action:**

**Problem Behavior:** Describe the problem behavior(s) for which the action is being requested by providing a measurable and observable description.

Behavior 1:

\_\_\_\_\_

\_\_\_\_\_

Behavior 2 (if applicable):

\_\_\_\_\_

\_\_\_\_\_

--

**Interventions** *(If you answer yes to question #1, please complete #2-4 and provide copy of FBA)*

1. Has a Functional Behavior Assessment (FBA) been conducted for target behaviors?  
 Yes

2. Date of last FBA?

3. Which behaviors described above are the target of the FBA?

4. Briefly describe hypothesis developed for each target behavior.

Behavior 1:

Behavior 2:

**Description of Behavior Plan**
*(Provide copy of Behavior Plan with application)*

1. Is there an intervention that modifies the antecedents including the setting events identified in the hypothesis so that the problem behavior is prevented? Describe below.

Behavior 1 <i>(identify behavior)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Behavior 2 <i>(identify behavior)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:

2. Is there an intervention that teaches the student replacement behavior? Describe below.

Behavior 1 <i>(identify behavior)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Behavior 2 <i>(identify behavior)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:

3. Is the replacement behavior a functionally equivalent replacement behavior (FERB) or an alternative, socially valid skill? *(If more than one replacement behavior is being taught, please check all that apply).*

Behavior 1	<input type="checkbox"/> FERB	<input type="checkbox"/> Alternate skill
Behavior 2	<input type="checkbox"/> FERB	<input type="checkbox"/> Alternate skill

4. Is there an intervention that reinforces the replacement behavior?

Behavior 1:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Behavior 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No
-------------	---	-------------	---

5. Does the reinforcement provide the same function (identified in the hypothesis) for the replacement behavior that resulted from the problem behavior?

Behavior 1:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Behavior 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No
-------------	---	-------------	---

6. Is there an intervention that describes how others will respond after the problem behavior so that it no longer provides reinforcement/functional outcome?

Behavior 1:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Behavior 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No
-------------	---	-------------	---

7. Are de-escalation interventions described?

Behavior 1:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Behavior 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No
-------------	---	-------------	---

8. Are the behavior intervention strategies described in enough detail so that a person unfamiliar with the plan could implement it with accuracy?

Behavior 1:	<input type="checkbox"/> Yes	Behavior 2:	<input type="checkbox"/> Yes
-------------	------------------------------	-------------	------------------------------

Office Use Only

	No		No
--	----	--	----

<b>Reinforcement</b> <i>(Provide current schedule, noting changes in environments, staffing or activities)</i>	
1. Type of choices offered the student each day? Provide an example of choices checked below.	
Between tasks	
Within tasks	
Where to do tasks	
The person with whom to do the task	
When to do the task	
Terminating the task	
Rejecting	
Other	
2. What reinforcement is provided to the student?	<i>Specify:</i>
3. How often is reinforcement delivered?	<i>Specify:</i>

<b>Data</b> <i>(Provide behavioral data for the student's 60 school days prior to the date of this request. For each problem behavior described above provide the following: (information can be provided in a chart, table or quantified summary statement that can be interpreted by someone unfamiliar with the program/ student)</i>				
<ul style="list-style-type: none"> <li>▪ Start date of data</li> <li>▪ End date of data</li> <li>▪ Baseline dates</li> <li>▪ Post – intervention dates</li> <li>▪ Average frequency/ duration/intensity of behavior within each phase of timeframe of measure</li> <li>▪ How were decisions made if the data did not show reduced rate of problem behavior(s) after intervention was implemented? What modifications were made to the Behavior Plan and what were the results of the modifications?</li> </ul>				
1. Was implementation fidelity collected?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If you answered yes to the above question, provide dates and scores.</i>	Date			
	Score			
2. How was fidelity measured? <i>(Check all that apply)</i>				
<input type="checkbox"/> <b>Teacher</b> self – assessments <input type="checkbox"/> <b>External</b> direct observation <input type="checkbox"/> <b>Anecdotal</b>				



**Restraint /Seclusion**

How often is mechanical restraint or seclusion used? *(Provide data from most recent school year. Data should include dates, frequency and duration.)*

What is the average duration of the mechanical restraint or seclusion action before the student returns to a safe state?

What is the range of duration? *(Least to most)*

**Classroom/School Information**

1. How many adults are in the classroom?

2. What is the adult: student ratio in the classroom?

3. What is the adult: student ratio provided for this student?

3. Does the school implement a continuum of multi-tiered behavioral supports?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

***If YES, how are students with disabilities who are in self-contained or separate classes included in the continuum of support?***

**Please submit the following documentation with the request form:**

\_\_\_\_\_ Release of Information (with parent/guardian signature)

\_\_\_\_\_ Student's IEP/ progress data

\_\_\_\_\_ Student's attendance record for 12 month period

\_\_\_\_\_ Student's schedule

\_\_\_\_\_ Functional Behavior Assessment (if completed)

\_\_\_\_\_ Behavior Intervention and/or Support Plan

\_\_\_\_\_ Implementation data for 60 school days prior to the date of request for all steps of Behavior Plan (chart, table, quantitative summary).

\_\_\_\_\_ Mechanical restraint / Seclusion Data (dates, frequency, duration)

\_\_\_\_\_ Peer Review report

\_\_\_\_\_ Incident reports related to request

\_\_\_\_\_ Data specified in the request form

## Considerations for Recommendations

### Related to Waiver Requests for Restraint and Seclusion

*Consideration 1: Does the waiver request provide data that proves effectiveness of action being requested?*

- (a) Non-physical interventions have not and /or would not be effective; and
- (b) The student's behavior poses a threat of imminent, serious, physical harm to self and/or others?

*Consideration 2: Does the waiver request provide data that show the requested action has been used correctly?*

- (a) Is there an indication that the action was used as a punishment procedure?
- (b) Is there an indication that the action was used as a response to property destruction, disruption of school order, a student's refusal to comply with a school rule or staff directive, or verbal threats that do not constitute a threat of imminent, serious, physical harm?
- (c) Is the requestor's training current?
- (d) Are the reporting and follow-up procedures being implemented as described by Delaware statutes?

*Consideration 3: Does the waiver request provide data/information showing other non-physical interventions that were in behavior plans included evidence-based components and were implemented with fidelity?*

- (a) Is there information showing that the applicant reviewed the behavior intervention plan in place and adjusted it to reduce use of the action?
- (b) Is there information showing that the applicant reviewed and considered medical, psychological, and physiological needs that contribute to the behaviors resulting in use of the action?
  - a. Are there indications that if the student has medical conditions that impact the behavior, strategies and/or suggestions were made for medical evaluations/interventions?

*Consideration 4: Does the waiver request provide data/information that shows the student's instructional program is appropriate? (Quality of Instructional Program)*

- (a) Is there information showing that the student has a consistent means of communication?
- (b) If no, is there information showing that the behavior intervention plan provides a functional communication replacement behavior?
- (c) Is there information showing that the applicant considered the educational environment including richness of instruction and opportunity for choices?

- (d) Is there information showing that adults are delivering reinforcement to the student for appropriate behaviors at a rate that is effective?
- (e) Does the applicant provide information showing that the teacher has adequate support?
- (f) Can the applicant describe the continuum of multi-tiered behavior supports used in their setting including how students with disabilities are included?

*Consideration 5: Does the waiver request provide information showing that the FBA and BIP in place for the student are evidence-based? (Quality of FBA and BIP)*

- (a) Is the FBA recent?
- (b) Does the FBA address the specific problem behaviors generating the requested actions?
- (c) Is a hypothesis included in the FBA?
- (d) Is the hypothesis appear to be linked to the FBA information?
- (e) Does the action being requested inadvertently reinforce the student? (look for the function identified in the hypothesis and the action being requested-does the action provide the hypothesized function)?
- (f) Is the intervention plan multicomponent?
  - a. Intervention to prevent (modifies the antecedent)
  - b. Intervention to teach a replacement behavior
    - i. Is the replacement behavior socially valid?
  - c. Intervention to reinforce the replacement behavior
  - d. Intervention that changes the response to the problem behavior
- (g) Are the interventions described in enough detail so that a naïve person (to the plan) could implement it with fidelity?
- (h) Is there evidence that the applicant used data for problem solving and adjusting the intervention plan and/or collecting more FBA data to inform the hypothesis?
- (i) Does the application indicate that the action is the primary intervention being used? (look for frequency of use and indications that other strategies are being implemented in addition to the action requested).