



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: Recent Regulatory & Policy Initiatives

Date: December 10, 2014

I am providing my analysis of five (5) regulatory and policy initiatives. Given time constraints, the commentary should be considered preliminary and non-exhaustive. Due to the small number of initiatives published in the December Register of Regulations, I understand that the P&L Committee meeting scheduled for December 11 has been cancelled.

1. DOE Mechanical Restraint and Seclusion Waiver Application & Review Guidance (10/1/14)

As background, S.B. No. 100, enacted in 2013, bans the use of mechanical restraint and seclusion in public schools in the absence of a waiver. The law was effective July 1, 2014. The Department of Education prepared the following in September, 2014: 1) implementing form for public schools to use in applying for a waiver; and 2) guidance on DOE processing of waiver applications. The SCPD and GACEC submitted similar comments on both documents in October, 2014. The Department responded by letter memorandum in November, 2014. Since the letter memorandum is formatted with the individual comment followed by the response, I am attaching it to facilitate review. In a nutshell, the Department was very receptive to the commentary. It adopted approximately twelve (12) revisions, deferred consideration of three (3) comments to later in the review process, and declined revisions based on three (3) comments. I recommend submitting a "thank you" communication for thoughtfully considering the analysis.

2. DMMA Medicaid Primary Care Payment Rate Regulation [18 DE Reg. 424 (12/1/14)]

The Division of Medicaid & Medical Assistance proposes to adopt a State Medicaid Plan amendment in the context of payments for primary care services and physician-administered vaccines.

As background, the Affordable Care Act required that Medicaid reimbursement for primary care providers and vaccine administration in 2013 and 2014 be no less than a Medicare fee schedule. DMMA adopted that methodology for Delaware's Medicaid program and apparently benefitted from enhanced (100%) federal funding. At p. 425. DMMA now proposes to continue the existing reimbursement rates into 2015 albeit with a lower federal subsidy, i.e., "the regular federal matching rate". At p. 425. The total fiscal cost in FFY15 will be \$147,691 in General (State) Funds and \$95,699 in Federal match. At p. 426.

I recommend endorsement subject to one (1) concern. The Plan Amendment recites that vaccine administration “shall be paid at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program.” At p. 428. This is “odd” wording. It is common to recite that a standard will be the lesser of “A” or “B”. It is peculiar to recite that a standard will be the lesser of “A”. DMMA may wish to clarify the standard.

I recommend sharing the above observations with the Division.

3. DMMA Medicaid Rehabilitative Services Regulation [18 DE Reg. 429 (12/1/14)]

As background, “rehabilitative services” are an optional Medicaid State Plan benefit. Delaware includes “rehabilitative services” within its State Plan. Under the general heading of “rehabilitative services”, the Delaware Medicaid Plan included a “Community Support Service Program” which covered “behavioral health rehabilitative services per persons with disabilities caused by mental illness and substance use disorder.” At p. 430. This program encompassed both residential and non-residential support services. Id. Details are contained in the relevant provider manual published at <http://www.dmap.state.de.us/downloads/manuals/Community.Support.Services.Provider.Specific.pdf>.

CMS has already approved an amendment to remove the “Community Support Service Program” entirely from the Medicaid State Plan effective January 1, 2015. At p. 430. The rationale for the deletion of the Program is that the PROMISE program makes it “obsolete”. Id. In a nutshell, support services previously provided under the Community Support Service Program” would be covered (along with other services) by PROMISE. DMMA is proposing to formally delete the Community Support Service Program” from the State Plan through the current proposed regulation.

I have the following observations.

First, I am concerned that eligibility for PROMISE is more circumscribed than eligibility under the Community Support Service Program. As a result, some classes of individuals who were eligible for behavioral health support services under the former program will be “left in the cold”. Consider the following:

A. Per the attached §5.0 from the Community Support Service Program Provider Manual, eligibility for the program was expansive and not limited by diagnosis:

5.0 Service Limitations

5.1. Eligibility Limitations

5.1.1 Community support services are limited to eligible DMAP clients who would benefit from services designed for or associated with mental illness, alcoholism or drug addiction.

5.1.1.2 Coverage for community support services is limited to those Medicaid clients who are certified by the program physician as severely disabled according to criteria for severity of disability caused by mental illness and/or substance abuse.

B. In contrast, the PROMISE program is highly prescriptive and only covers individuals with certain diagnoses. See attached excerpt from Medicaid Plan amendment.

While individuals with a TBI diagnosis could have qualified under the "Community Support Service" eligibility standard, that diagnosis is non-qualifying under PROMISE. The SCPD and GACEC have requested reconsideration of DMMA's exclusion of TBI as a qualifying diagnosis under PROMISE. See attachments. Apart from TBI, there may be a host of other classes of individuals who would have been eligible under the Community Support Service" program but who will be barred from PROMISE based on a non-qualifying diagnosis, including the following:

- 1) intermittent explosive disorder (DSM V, 312.34);
- 2) conduct disorder (DSM V, 312.81, 312.82, and 312.89);
- 3) all neurocognitive disorders (DSM V, pp. 591-642); and
- 4) all trauma- and stressor-related disorders apart from PTSD (DSM V, pp. 265-290).

Second, DMMA indicates that PROMISE is intended to cover individuals qualifying under the DOJ-Delaware settlement. At p. 430. The population of individuals covered by the Settlement Agreement is not limited to certain diagnoses. See attached pp. 2-3 from Settlement Agreement. As a result, while an individual in DPC with a diagnosis of intermittent explosive disorder will qualify for services under the Settlement Agreement, DHSS will have to spend 100% State funds for the individual's community programming since the person lacks a qualifying diagnosis to be eligible for PROMISE. Alternatively, the individual will be relegated to a narrow scope of services offered by an MCO. See attached Waiver Amendment, p. 9. Query whether these results are fiscally and clinically prudent.

In closing, while the Division characterizes the Community Support Services program as "obsolete" as supplanted by the PROMISE program, this is not entirely accurate. It is unfortunate that the Division is proposing elimination of a program with more progressive eligibility criteria and substituting a program with brittle, no-exceptions diagnosis-based eligibility criteria.

I recommend sharing the above observations with DMMA, DSAMH, the DHSS Secretary, and Court Monitor. Given the exclusion of neurocognitive disorders (including Alzheimer's), the Councils may wish to share a courtesy copy of comments with the AARP.

4. DOE Medications & Treatments Regulation [18 DE Reg. 419 (12/1/14)]

As background, legislation (S.B. No. 246) was enacted in July, 2014 which requires the Department to issue implementing regulations. A copy of the engrossed bill is attached for facilitated reference.

The legislation indicates that the federal School Access to Emergency Epinephrine Act was passed in 2013. The federal Act establishes a preference in receiving certain federal grants to states which adopt laws addressing administration of epinephrine to students experiencing anaphylactic reactions. The preamble to S.B. No. 246 includes the following statistics:

- 1 in 25 school aged children are affected by food allergies, the most common trigger of anaphylaxis;
- approximately 16-18% of children with food allergies have experienced a reaction in school; and
- approximately 25% of all anaphylaxis cases occur in children whose food allergy was previously undiagnosed.

I have the following observations.

First, §3002E(a) of the statute requires the DOE regulation to address documentation of the training of “Trained Persons”. The implication is that the legislators envisioned record keeping of written confirmation of completion of training. In contrast, the regulation (§6.1.2) merely contemplates the written representation of personnel that he/she has completed training. Reasonable persons might differ on whether a self-reporting approach is prudent, especially given the risk of death if epinephrine is not properly administered. It should not be burdensome to require personnel to submit proof of completion of a Board of Nursing training course.

Second, a related concern is the “weakening” of the record-keeping system for trained personnel. The regulation deletes a current requirement that a school nurse essentially act as a point person to send the Department of Education a list of educators who have completed the training:

A School Nurse shall:

6.1.2.1. Complete instructor training as designated by the Department of Education ~~and shall submit a list of educators and other school employees, who have completed the training to the Department of Education.~~

It would be much easier for the Department to monitor implementation of the regulation if schools supplied a list of trained personnel. Otherwise, the Department would be completely unaware if multiple schools had zero trained personnel. Some DOE monitoring of implementation is contemplated since the school nurse is required (§7.5) to submit an emergency medication summary sheet to the DOE within 48 hours of use of an emergency medication. Moreover, the statute [§3005E(a)] requires schools to “identify and train a sufficient number of eligible persons”. If no information on the number of trained personnel is submitted to DOE, query how it will monitor compliance with this statutory standard?

Third, the statute [§3005E(b)] contains the following provision:

Except for a school nurse, an educator, coach or person hired or contracted by schools serving students in pre-kindergarten through grade 12 shall not be compelled to become a Trained Person, unless this is a requirement of hire or contract.

In contrast, the regulation contains inconsistent standards implementing this provision:

- 7.2.1 An identified person cannot be compelled to become a Trained Person, unless training is a requirement of their position, hire, or contract.
- 8.0. Except for a School Nurse, no Educator or Other School Employee shall be compelled to assist a student with medication or administer emergency medication.

The latter section omits the caveat that personnel can be compelled to fulfill the qualifications and role of a Trained Person if “a requirement of hire or contract”.

Fourth, in §2.0, the definition of “Assistance with Self-Administration of Medication” is problematic. It includes the following provision:

The one exception is with emergency medications where standard emergency procedures prevail ~~in lifesaving circumstances~~ for life threatening symptoms of a diagnosed condition and includes the administration of the medication based on the healthcare provider’s order and parent permission.

The definition of “Emergency Medication for a Diagnosed Medical Condition” is similarly limited to “a diagnosed medical condition”.

Consistent with the preamble to S.B. No.246, approximately 25% of all anaphylaxis cases occur in children whose food allergy was previously undiagnosed. See also regulatory §7.1.2. Therefore, the reference to “a diagnosed condition” is unduly limiting. Likewise, since the condition may be undiagnosed, there may be no provider’s order and no parent permission.

The DOE could simply delete the entire sentence since it is superfluous. There is no need to include the emergency standards within the definition of Assistance with Self-Administration of Medication. The balance of the regulation provides ample guidance on emergency situations.

Fifth, in §2.0, the definition of “medication” includes a categorical requirement that it “has been authorized for a student to use”. There is some “tension” between that definition and the authorization to administer an emergency “medication” for an allergic reaction based on an undiagnosed condition. There will be no prior authorization from a health care provider or parent since the condition is undiagnosed.

Sixth, in §2.0, the definition of “paraeducator” is unduly limiting. It recites that the term means “teaching assistants or aides in a school”. This could exclude a “service paraeducator” [14 DE Admin Code 1517] who might provide assistance to a student in extracurricular or off-site activities. If a paraeducator were to become a “Trained Assistant for Self-Administration” or a “Trained Person”, the paraeducator could be working outside a building “at an Approved School Activity” [§6.1.4] such as a field trip, team competition, or playground recess. Cf. attached October 17, 2013 Delaware News Journal article noting allergic reactions due to wasp sting or eating peanut on playground.

Seventh, for similar reasons, §7.1 should be amended. It literally only allows administration of an emergency medication “in the school building”.

Eighth, §6.1 only permits Trained Assistants for Self-Administration to act during approved school activities “in kindergarten through Grade 12”. This omits preschool activities which are expected to be covered. See 14 Del.C. §3001E(3) and regulatory §2.0, definition of “school”. Compare reference to “pre-kindergarten through Grade 12” in §6.1.4.

Ninth, the original version of S.B. No. 246 addressed emergency responses to asthma attacks. The explicit references to asthma were deleted by S.A. No. 1. Apart from food allergies, emergency administration of Diastat for seizures and glucagon for symptoms of diabetes are authorized in some states. See attached Epilepsy Legal Defense Fund, “Diastat Administration in Schools: Summary of Relevant Federal Laws and Selected Cases” at p. 1. S.B. No. 246 defines “emergency medication” as one responsive to an “allergic reaction”. This limitation is mirrored in the regulation, §2.0. Schools are directed to maintain “current, stock Emergency Medication” [§7.3]. It would be “progressive” if the DOE expanded the scope of emergency medications beyond those for allergic reactions. If legislation were needed to facilitate a broader approach, that could be considered.

I recommend sharing the above observations with the DOE. A courtesy copy of comments could be shared with the Division of Public Health and the prime sponsors of S.B. No. 246, Sen. Hall-Long and Rep. Barbieri. Parenthetically, I was unable to locate a copy of the DPH guidance mentioned at §7.1.2 and in the final “Whereas” clause in S.B. No. 246. The Councils may wish to request a copy from the Division.

5. DFS Rev. Proposed Early Care & Education & School-Age Ctr. Reg. [18 DE Reg. 438 (12/1/14)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2014. A copy of the SCPD’s June 25, 2014 letter (minus attachments) is included for facilitated reference. Rather than adopt a final regulation, the Division of Family Services has now issued a revised proposed set of proposed regulations. The standards are lengthy, i.e., 69 pages.

1. Preliminarily, the Councils promoted the incorporation of more robust non-discrimination language than the brief reference in §25.1.3. Section 35.1.2 has been amended to include an assurance of non-discrimination based on disability and other protected classes. It could be improved by including a specific reference to the ADA and Delaware’s equal accommodations statute consistent with the Attorney General’s opinion (p. 4) included with the Councils’ June commentary.

2. In their June commentary, the Councils objected to authorization for children to ride bikes without helmets if the bike has wheels of less than 20 inches in diameter. Section 41.0 remains unchanged and the comment should be reiterated. In other contexts, DFS has adopted good standards to prevent injuries [e.g. trampoline ban (§40.5); protective surfacing (§40.8)].

3. In their June commentary, the Councils recommended adoption of a requirement of notification to DFS for each administration of extended physical restraint. No change to §13.0 has been made. The comment should be reiterated.

4. In §3.0, the definition of IEP recites that it covers the educational program “for a child three (3) years of age or older”. This is not entirely accurate. Children with certain classifications are eligible under IDEA-B for an IEP at birth. See Title 14 Del.C. §3101(3) and §1703(k)(l)(m).

5. In §19.1, there is an extraneous “129”.

6. Section 43.2 allows a provider to have 1 toilet for 15 school-age children plus staff. For younger children, the standard is 1 toilet for every 10 children aged 24 months through preschool plus staff. I recommend consideration of a lower ratio. Ready access to a toilet is not provided under this arrangement. The Councils recently criticized continuation of a 1-8 individual-toilet ratio for family care homes in commenting on a proposed regulation published at 18 DE Reg. 282 (10/1/14). Other regulations require 1 toilet for every four (4) individuals. See the neighborhood home regulation [requiring 1 toilet for every four (4) individuals (16 DE Admin Code 3310, §9.0)]. See also 16 DE Admin Code 3230, §5.9, and 16 DE Admin Code 3301, §5.9. Moreover, toddlers and children may need assistance in toileting and “turnover” may not be quick.

7. DFS may wish to review the proposed DOE regulation published this month [18 DE Reg. 419 (12/1/14)] regarding emergency administration of medications in the event of allergic reactions. The DOE regulation covers pre-kindergarten programs in schools. See §2.0, definition of “school”. There may be overlapping jurisdiction with DFS over some programs. Compare §§3.2 and 3.3 (DFS regulation covers early care and school age centers within schools). DFS may wish to promote compatibility between its standards (e.g. §§60-61) and the DOE standards in the context of emergency interventions related to allergic reactions. Section 61.2 generally authorizes staff to “take appropriate emergency action” in response to allergic reactions.

Attachments

E:legis/1214bils
F:pub/bjh/legis/2014p&l/1214bils



DEPARTMENT OF EDUCATION

The Townsend Building
401 Federal Street Suite 2
Dover, Delaware 19901-3639
DOE WEBSITE: <http://www.doe.k12.de.us>

Mark T. Murphy
Secretary of Education
Voice: (302) 735-4000
FAX: (302) 739-4654

November 18, 2014

Ms. Wendy Strauss, Executive Director
Governor's Advisory Council for Exceptional Children
George V. Massey Station
516 West Loockerman Street
Dover, DE 19904

Dear Ms. Strauss:

The Delaware Department of Education (DDOE) is in receipt of your letter dated October 9, 2014 (received October 23, 2014) with comments regarding the proposed **Mechanical Restraint and Seclusion Waiver Request** form and **Waiver Review Considerations** document. All comments were taken into consideration in the final revision of each document.

Request For Individual Student Waiver for Mechanical Restraint(s) or Seclusion

GACEC Comment

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 the Office of Civil Rights (OCR).

DDOE Response

Under **STUDENT INFORMATION** on cover page, "IEP" and "504 Plan" were added to the section entitled **Primary/Secondary Disabilities**.

GACEC Comment

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. Council assumes the inquiry is intended to elicit information about conditions such as Attention Deficit/Hyperactivity Disorder (ADHD) or Traumatic Brain Injury (TBI) which could contribute to problematic behavior. The DOE could consider adding a clarifying example. Parenthetically, Council would also recommend substituting "the student's" for "their" to avoid the use of a plural pronoun ("their") with a singular antecedent ("student").

DDOE Response

The following language was added to clarify #2 under section entitled **STUDENT HEALTH** (pg 2) :
Does the student have any medical conditions that impact and/or contribute to his/her performance of problem behavior? (i.e. Seizures, ADHD, TBI, Migraines)*

** medical clearance by appropriate professional in writing must accompany this request*

GACEC Comment

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).

DDOE Response

STUDENT HEALTH title has the following qualifier in parentheses: *(If student has documented physical (ie. brittle bones) or psychological considerations written clearance for mechanical restraint or seclusion by appropriate professional must be provided.)*

GACEC Comment

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.

DDOE Response

Under section entitled **Type of Waiver Requested** (pg 3) and below the definition of Seclusion the following line item was added: **Duration of waiver requested**
Additionally, on the **Scoring Matrix the Recommendations** include **Duration of Waiver**, (if granted) and any applicable conditions.

GACEC Comment

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".

DDOE Response

The following revision was made: **"Describe the problem behavior(s) for which the waiver is being requested by providing a measurable and observable description."**

GACEC Comment

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.

DDOE Response

Upon review of this item, the committee feels the current language most accurately describes the information being requested.

GACEC Comment

G. In the "Data" section, the following reference is unclear: " 1. Was implementation fidelity collected?" Perhaps DOE intended to say "(w)as data/information related to implementation fidelity collected?"

DDOE Response

The following revision was made: " 1. Was data related to implementation fidelity collected?"

GACEC Comment

H. Council recommends 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 nine months, whichever is longer.

DDOE Response

See revision of section noted in next comment response.

GACEC Comment

I. The "Restraint/Seclusion" section is unusual 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 the use of a time-out is effective or has not been attempted, there may be little need to approve the use of 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.

DDOE Response

This section was revised as follows:

1. How often is mechanical restraint or seclusion used? *(Provide mechanical restraint/ seclusion data in the school year prior to July 1,2014 if applicable OR if renewal request provide current data including dates, frequency and duration.)*
2. What is the average duration of the mechanical restraint or seclusion action before the student returns to a safe state?
3. What is the range of duration? *(Least to most)*
4. Is physical restraint currently being used? ____ Yes ____ No
If YES, provide 60 school days of data including dates, frequency and duration
5. Is Time Out currently being used? ____ Yes ____ No
If YES, provide 60 school days of data including dates, frequency and duration

GACEC Comment

J. In the "documentation" section, Council recommends adding "\$504 plan".

DDOE Response

Revised as suggested.

Guidance: Waiver Review Considerations

GACEC Comment

A. In the title, the GACEC recommends inserting "Mechanical" prior to "Restraint".

DDOE Response

Revised as suggested.

GACEC Comment

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

DDOE Response

The guidance document is still under review and revision. Your comments will be addressed in final draft.

GACEC Comment

C. "Consideration 2" envisions assessing data on the 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.

DDOE Response

The document is still under review and revision. Your comments will be addressed in final draft.

GACEC Comment

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

DDOE Response

Duration of Waiver Approval and Conditions of Waiver Approval will be included in Recommendations

GACEC Comment

E. In "Consideration 5", Council recommends 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.

DDOE Response

Revised as suggested.

GACEC Comment

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.

Ms. Wendy Strauss
November 18, 2014
Page 5

DDOE Response

At this time, committee is drafting language related to "Conditions of Approval" and will consider your comments in the discussion.

GACEC Comment

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.

DDOE Response

Prompting is provided the **Mechanical Restraint and Seclusion Wavier Request Matrix**

GACEC Comment

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.

DDOE Response

Prompting is provided the **Mechanical Restraint and Seclusion Wavier Request Matrix**

DDOE appreciates the time and effort GACEC has provided in the development and promulgation of these documents. If you have any specific questions about this information, please feel free to contact me.

Sincerely,


Tina M. Shockley

cc: The Honorable Mark Murphy, Secretary of Education
Dr. Teri Quinn Gray, State Board of Education
Susan Haberstroh, Department of Education
Michael Watson, Department of Education
Mary Ann Mieczkowski, Department of Education
Michelle Whalen, Department of Education
Paula Fontello, Esq.
Terry Hickey, Esq.
Ilona Kirshon, Esq.

5.0 Service Limitations

5.1 Eligibility Limitations

5.1.1 Community support services are limited to eligible DMAP clients who would benefit from services designed for or associated with mental illness, alcoholism or drug addiction.

5.1.2 Coverage for community support services is limited to those Medicaid clients who are certified by the program physician as severely disabled according to criteria for severity of disability caused by mental illness and/or substance abuse.

5.2 Appropriate Use

5.2.1 The program provider must complete a comprehensive medical/psychosocial assessment within 30 days of the client's admission to the program.

5.2.2 The program physician must certify that the Community Support Services are medically necessary. DSAMH may at any time review any client's treatment record to verify that the evaluation, treatment plan and certification of medical necessity are complete. DSAMH may require a full review of medical necessity in the event that a determination of medical necessity by the program physician does not appear to be supported by the assessment materials.

5.2.3 Providers will not be reimbursed for services provided after 60 days of admission to the program or beyond 15 days of the yearly anniversary date of admission to the program without a completed assessment, treatment plan and physician's certification of medical necessity.

5.3 Service Utilization

5.3.1 Services provided to each client must be medically necessary and in accordance with the prescribed treatment plan.

5.3.2 Services shall not be provided primarily for the convenience of the provider or the client.

5.4 Location of Service Provision

5.4.1 Providers may not bill DMAP for services provided to a client while they reside in an institution for mental diseases or in a correctional institution.

5.5 Sub-Contracting of Services

5.5.1 Services billable to DMAP are limited to those provided by an employee of the certified provider agency or by a physician or other qualified staff person directly

EXCERPT

1115 Demonstration Amendment for State of Delaware PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) Program Changes

August 22, 2014

Introduction

The State of Delaware (State) is seeking an amendment to their existing 1115 demonstration waiver to comprehensively meet the needs of individuals with behavioral health (BH) needs, including individuals identified under the State's Olmstead settlement with the United States Department of Justice. The 1115 demonstration amendment is being submitted following submission of a State Plan Amendment (SPA) for crisis intervention, substance use disorder (SUD) treatment, and treatment by other licensed practitioners.

The PROMISE program seeks authority to target individuals with behavioral health needs and functional limitations in a manner similar to an Home and Community-Based Services (HCBS) 1915(i) State Plan authority. The HCBS authority under an 1115 amendment is sought, instead of a 1915(i) State Plan Amendment, to ensure coordination with the Diamond State Health Plan (DSHP) Plus program, to allow the State to include State Plan BH services in the managed care organization (MCO) benefit package, and to allow the State to competitively procure vendors under its new HCBS BH program, identified as PROMISE (*Promoting Optimal Mental Health for Individuals through Supports and Empowerment*). The demonstration amendment ensures that the freedom of choice waiver required for the procurement under this new HCBS program is granted under the State's current 1115 demonstration waiver and includes all affected individuals' costs under a single Centers for Medicare and Medicaid Services (CMS) authority. In particular, because of the small size of the State and low volume of services needed, the State will be competitively procuring contractors under the demonstration to meet the high quality and fidelity standards required under the Olmstead ADA settlement.

- For adult Medicaid populations meeting targeting and functional limitations statewide, the State will offer an enhanced benefit package of HCBS using HCBS authority in the 1115 demonstration. Generally, this includes individuals meeting the Olmstead settlement BH target population as well as other Medicaid-eligible adults with serious mental illness and/or substance use disorder needs requiring HCBS to live and work in the most integrated setting. These services are provided in addition to the State Plan services to help maintain individuals in home and community-based settings. The enhanced Medicaid benefit package will be coordinated by the Division of Substance Abuse and Mental Health (DSAMH) through the fee-for-service (FFS) program in compliance with home and community-based standards and assurances and the signed Olmstead agreement. *This population will continue to receive non-BH and most non-enhanced BH Medicaid State Plan services through the MCO benefit. See the benefit sections below for a description of the covered services.* The State is also considering including non-medical transportation services in the State's existing transportation broker contract and this amendment would provide the freedom of choice authority necessary for that contract amendment.
- For adults served in MCOs throughout the State who are not in the PROMISE target populations, the MCOs will integrate all covered services for mental illness, SUDs, and physical health (PH) conditions under this demonstration.

The goals of the two delivery system models are to improve clinical and recovery outcomes for individuals with BH needs and reduce the growth in costs through a reduction in unnecessary

institutional care through care coordination, including initiatives to increase network capacity to deliver community-based recovery-oriented services and supports. This structure will also ensure care continuity for individuals depending on their levels of need.

Background

Many individuals who are not currently eligible for Medicaid receive critical BH services through State-only funds, federal block grant dollars, or other resources. Although the State already has expanded Medicaid eligibility, many of the individuals served in the BH system who have not historically been eligible for Medicaid become eligible for Medicaid under health care reform in 2014. Under this proposed demonstration amendment, the State plans to develop access to additional supports and services to better meet the BH needs of the Medicaid expansion population in 2014 and to better serve the target populations under the Olmstead settlement. These efforts are aimed at modernizing and improving the delivery of mental health and substance use services in Delaware to better meet the needs of those currently eligible, but also to build the foundation to ensure that there is a robust continuum of supports and evidenced-based options available in the future. It is the State's intention to offer the expansion population the same benefit package as the rest of Medicaid with any necessary wraps to ensure essential health benefits.

The management of severe and persistent mental illness (SPMI) and chronic and disabling SUD require specialized expertise, tools, and protocols which are not consistently found within most medical plans. As a result, for adult populations meeting the SPMI and SUD targeting and functional criteria statewide, specialty BH care within the State will be care managed by DSAMH on a FFS basis with MCO care managers participating in person-centered planning with DSAMH and the participants to fully integrate PH needs with BH needs.

The demonstration amendment seeks to address the issues arising from special needs populations with SPMI and/or SUD through a comprehensive, interconnected approach to providing services to all individuals with BH needs in Delaware, ensuring that the individuals served are receiving the most appropriate services to meet their needs in the most integrated settings possible.

PROMISE Program

In order to better treat individuals meeting SPMI and SUD targeting and functional needs criteria, Delaware will be providing an enhanced benefit package of HCBS services to adults (ages 18 and older) meeting the targeting and functional needs criteria for SPMI and SUD under the PROMISE program. All individuals who meet the targeting and functional needs criteria will receive specialized care management and care coordination consistent with established protocols for managing care for adults with SPMI and/or SUD. This includes providing for behavioral supports in community-based settings (individuals' own homes), as well as residential, employment, and day settings to help individuals live in the most integrated setting possible. DSAMH, through its network of care managers and providers, will ensure that all HCBS requirements and assurances are met. This initiative is intended to fundamentally meet the requirements of the Olmstead agreement signed with the United States Department of Justice, and to build a sustainable behavioral health system for Delaware.

PROMISE Eligibility Requirements

Demonstration enrollees applying for services must be screened by DSAMH using a standardized clinical and functional assessment developed for Delaware and based on national standards.

Individuals in PROMISE will not be eligible for the State's new Pathways 1915(i) State Plan Amendment Program because the PROMISE program is a more comprehensive program that includes all Pathways services as well as other services necessary for individuals with behavioral health needs to be supported in their homes. The Delaware-specific American Society for Addiction Medicine (ASAM) tool integrates the assessment and evaluation of both mental health and SUD conditions into a single document with an algorithm that can be used to determine functional eligibility and is designed to ensure appropriate treatment of individuals based on their medical and functional needs. State Medicaid eligibility staff will review financial criteria to ensure that applicants meet the community financial eligibility criteria. Individuals eligible for and enrolled in PROMISE may also be enrolled in the PLUS program if meeting the criteria for both programs unless the PROMISE individual has been identified as a CRISP individual under the ADA settlement. If the individual is identified as a CRISP individual, the individual will be enrolled in the PROMISE program only and will receive all services necessary for community living from the PROMISE program through CRISP. The CRISP program will not provide any services under the acute care MCO benefit. The PROMISE program will ensure that Medicaid payments are backed out of any state-only capitated payments made for the CRISP program thus ensuring no duplicate payment between CRISP/PROMISE and Plus. For individuals in PROMISE and PLUS, medically necessary PROMISE services will be provided in addition to any services that the individual is otherwise eligible for in PLUS if the individual is assessed as needing additional services and the services are outlined on the individuals Recovery Plan. The PROMISE care manager will coordinate with the Plus case manager, who will lead the individual's care team. To be eligible under the PROMISE HCBS program, individuals must meet one of the targeting criteria and the corresponding functional criteria under the Delaware-specific tool. The following are acceptable combinations for individuals eligible under the demonstration:

- Target criteria A and functional criteria A or C.
- Target criteria B and functional criteria B or C.

Targeting Criteria

Target Criteria A: An individual must have formally received one of the included Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses that constitute the targeted portion of the State's definition of SPMI, or a diagnosis of post-traumatic stress disorder (PTSD) by a qualified clinician. Diagnoses include the following:

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
295.10	295.90	Schizophrenia, Disorganized Type <i>(In DSM 5 Disorganized subtype no longer used)</i>	Psychotic Disorders ¹
295.20	295.90	Schizophrenia, Catatonic Type <i>(In DSM 5 Catatonic subtype no longer used)</i>	Psychotic Disorders
295.30	295.90	Schizophrenia, Paranoid Type <i>(In DSM 5 Paranoid subtype no longer used)</i>	Psychotic Disorders
295.40	295.40	Schizophreniform Disorder	Psychotic Disorders
295.60	295.90	Schizophrenia, Residual Type <i>(In DSM 5 Residual subtype no longer used)</i>	Psychotic Disorders
295.70	295.70	Schizoaffective Disorder	Psychotic Disorders

¹ In DSM 5, the associated diagnostic category is labeled, "Schizophrenia Spectrum and Other Psychotic Disorders".

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
295.90	295.90	Schizophrenia, Undifferentiated Type (<i>In DSM 5 Undifferentiated subtype no longer used</i>)	Psychotic Disorders
296.30	296.30	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders ²
296.32	296.32	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders
296.33	296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specifier</i>)	Mood Disorders
296.34	296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ³	Mood Disorders
296.40	296.40	Bipolar I Disorder, Most Recent Episode Hypomanic ⁴	Mood Disorders
296.42	296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	Mood Disorders
296.43	296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specifier</i>)	Mood Disorders
296.44	296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁵	Mood Disorders
296.50	296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	Mood Disorders
296.52	296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	Mood Disorders
296.53	296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/o Psychotic Features (<i>In DSM 5, "Without Psychotic Features" is not a further specifier</i>)	Mood Disorders
296.54	296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe w/ Psychotic Features (<i>In DSM 5, "With psychotic features" is its own specifier, and, when present, is used instead of Mild, Moderate, or Severe, not in addition to Severe</i>) ⁶	Mood Disorders
296.60		Bipolar I Disorder, Most Recent Episode Mixed, Unspecified (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.62		Bipolar I Disorder, Most Recent Episode Mixed, Moderate (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.63		Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders

² In DSM 5, mood disorders are broken out into "Depressive Disorders" and "Bipolar and Related Disorders".

³ The DSM 5 code for Major Depressive Disorder, Recurrent, with Psychotic Features is 296.34.

⁴ In DSM 5 code 296.40 is also used for "Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified".

⁵ The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Manic, with Psychotic Features" is 296.44.

⁶ The DSM 5 code for "Bipolar I Disorder, Current or Most Recent Episode Depressed, with Psychotic Features" is 296.54.

DSAMH Current SPMI Diagnosis Codes (updated 7/1/2012)			
DSM IV Code	DSM 5 Code	Disorder	DSM IV Category
296.64		Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features (<i>This Bipolar 1 sub-type was removed from DSM 5</i>)	Mood Disorders
296.70	296.70	Bipolar Disorder, Most Recent Episode Unspecified	Mood Disorders
296.89	296.89	Bipolar II Disorder	Mood Disorders
297.1	297.1	Delusional Disorder	Psychotic Disorders
301.0	301.0	Paranoid Personality Disorder	Personality Disorders
301.20	301.20	Schizoid Personality Disorder	Personality Disorders
301.22	301.22	Schizotypal Personality Disorder	Personality Disorders
301.83	301.83	Borderline Personality Disorder	Personality Disorders
309.81	309.81	Posttraumatic Stress Disorder (PTSD)	Anxiety Disorders ⁷

Target Criteria B: Individuals may also meet other targeted DSM diagnoses. The DSM diagnosis must be among those that are included in the following larger DSM categories (excluding pervasive developmental disorders):

- Mood Disorders:
 - *In DSM 5 “Depressive Disorders” and “Bipolar and Related Disorders” are separated out as diagnostic groupings.*
- Anxiety Disorders:
 - *DSM 5 includes a separate category, “Obsessive-Compulsive and Related Disorders”.*
 - *DSM 5 includes a separate category, “Trauma- and Stressor-Related Disorders”.*
- Schizophrenia and Other Psychotic Disorders:
 - *In DSM 5 this category is labeled, “Schizophrenia Spectrum and Other Psychotic Disorders”.*
- Dissociative Disorders
- Personality Disorders
- Substance-Related Disorders:
 - *In DSM 5 this category is labeled, “Substance-Related and Addictive Disorders”.*

Functioning Criteria

Each person who is screened and thought to be eligible for PROMISE must receive the State-required diagnostic and functional assessment using the Delaware-specific ASAM tool.

⁷ In DSM 5, PTSD is moved to another diagnostic category, called “Trauma- and Stressor-Related Disorders”.

Functional Criteria A: If the individual meets Targeting Criteria A, the individual must be assessed with a rating of moderate on at least one of the six Delaware-specific ASAM dimensions. The six dimensions include the following⁸:

1. Acute intoxication and/or withdrawal potential — substance use.
2. Biomedical conditions/complications.
3. Emotional/behavioral/cognitive conditions or complications (with five sub-dimensions, including suicidality, self-control/impulsivity, dangerousness, self-care, and psychiatric/emotional health).
4. Readiness to change (with two sub-dimensions, including understanding of illness and recovery, and desire to change).
5. Relapse, continued use, continued problem potential.
6. Recovery environment (with two sub-dimensions, including recovery environment and interpersonal/social functioning).

Functional Criteria B: If the individual does not meet Targeting Criteria A, but does meet Targeting Criteria B, the individual must be assessed with a rating of severe on at least one of the above six Delaware-specific ASAM dimensions.

Functional Criteria C: An adult who has previously met the above targeting and functional criteria and needs subsequent medical necessary services for stabilization and maintenance. The individual continues to need at least one HCBS service for stabilization and maintenance (i.e., at least one PROMISE service described below in Table 3).

PROMISE Benefits and Cost-Sharing

Effective with MCO re-procurement, adults under PROMISE will receive through MCOs all non-BH Medicaid State Plan services, as well as the following State Plan non-enhanced BH services:

- Hospital (inpatient general hospitals including BH stays in psychiatric units⁹; emergency room (ER); outpatient; inpatient psychiatric care the age 21¹⁰).
- Physician — all types except for psychiatric providers employed by and providing supervision to the PROMISE program services of assertive community treatment (ACT), intensive case management (ICM), and residential supports.
- Pharmacy — all excluding medication assisted treatment.
- Crisis intervention.

The following BH State Plan services will be provided FFS with care coordination through DSAMH for adults receiving services under PROMISE:

- SUD services including medication assisted treatment.
- Services by licensed BH practitioners.

⁸ 2nd edition ASAM by Dr. David Mee-Lee et al. at <http://www.asam.org/publications/patient-placement-criteria/ppc-2r>.

⁹ 42 CFR 440.10.

¹⁰ 42 CFR 440.160. Note: because this program is for individuals ages 18 and over, this reference to adults in inpatient psychiatric care under age 21 refers to individuals ages 18-21 as indicated under the approved Delaware State Plan.



Governor's Advisory Council for Exceptional Citizens (GACEC) 516 West Loockerman St., Dover, DE 19904
302-739-4553 (voice) 302-739-6126 (fax) <http://www.gacec.delaware.gov>

MEMORANDUM

DATE: November 21, 2014

TO: The Honorable Rita Landgraf, Secretary
Department of Health and Social Services (DHSS)

FROM: Robert D. Overmiller, Chairperson
Governor's Advisory Council for Exceptional Citizens (GACEC)

RE: Diamond State Health Plan Waiver Amendment - Promoting Optimal
Mental Health for Individuals through Supports and Empowerment
(PROMISE)

Greetings Secretary Landgraf:

The Governor's Advisory Council for Exceptional Citizens (GACEC) expressed support and endorsed comments made by the Disabilities Law Program (DLP) in reference to the proposed Diamond State Health Plan Waiver amendments and final regulations. Since the Division declined to adopt the recommendations of the DLP, we ask that you review the decision to not include traumatic brain injury (TBI) as a stand-alone qualifying diagnostic category. A copy of our letter on the final regulations and a copy of the DLP comments are attached for your reference.

Please contact me or Wendy Strauss at the GACEC office if you have any questions on our request. Thank you for your consideration.

Attachments

**GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS**

GEORGE V. MASSEY STATION
516 WEST LOOCKERMAN STREET
DOVER, DELAWARE 19904
TELEPHONE: (302) 739-4553
FAX: (302) 739-6126

November 21, 2014

Sharon Summers
Planning & Policy Development Unit
Division of Medicaid & Medical Assistance
1901 N. DuPont Hwy.
P.O. Box 906
New Castle, DE 19720-0906

**Re: DMMA Final DSHP 1115 Demonstration Waiver Amendment – Covering PROMISE
[18 DE Reg. 371 (11/01/14)]**

Dear Ms. Summers:

The Governor's Advisory Council for Exceptional Citizens (GACEC) submitted a letter to you in September of 2014 expressing our support and endorsement of comments provided by the Disabilities Law Program (DLP) in reference to the proposed Diamond State Health Plan Waiver amendments. A copy of the DLP letter is attached for your reference. In that letter, the DLP endorsed the proposed regulation subject to the adoption of two recommendations. Those recommendations were as follows:

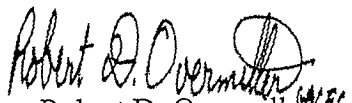
First, the Division was encouraged to amend the "target criteria" to include "Major Neurocognitive Disorder Due to TBI". The Division declined to adopt a conforming amendment.

Second, the Division was encouraged to resolve ostensibly inconsistent references to choice of providers. The Division declined to adopt an amendment.

The GACEC will be sending a memo to Secretary Landgraf of the Department of Health and Social Services (DHSS) requesting that she review the decision of the Division to not include traumatic brain injury (TBI) as a stand-alone qualifying diagnostic category given the potential value of the program to individuals with a diagnosis of traumatic brain injury. We support the expansion of services for this traditionally under-served population.

If you have any questions on our comments, please contact me or Wendy Strauss at the GACEC office.

Sincerely,


Robert D. Overmiller
Chairperson

RDO:kpc

Enclosure



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

September 22, 2014

Sharon Summers
Planning & Policy Development Unit
Division of Medicaid & Medical Assistance
1901 N. DuPont Hwy.
P.O. Box 906
New Castle, DE 19720-0906

Re: Proposed DSHP 1115 Waiver Amendment Covering PROMISE

Dear Sharon:

Please consider this letter and attachments as commentary submitted in response to the solicitation appearing at <http://www.dhss.delaware.gov/dhss/dsamh>. A link at that Web location connects to a 38-page document dated August 22, 2014 entitled "1115 Demonstration Amendment for State of Delaware PROMISE (Promoting Optimal Mental Health for Individuals through Supports and Empowerment) Program Changes", hereinafter "Amendment".

As background, I understand that DHSS is proposing an amendment to the DSHP 1115 Waiver to offer an enhanced benefits package to eligible persons. The target population is described as "individuals meeting the Olmstead settlement BH target population as well as other Medicaid-eligible adults with serious mental illness and/or substance abuse disorder needs requiring HCBS to live and work in the most integrated setting." Amendment, p. 1. Specific eligibility standards are outlined at pp. 3-6.

The enhanced benefit package (pp. 7-8) includes the following fifteen (15) supports:

- care management
- benefits counseling
- community psychiatric support and treatment
- community-based residential supports, excluding assisted living
- financial coaching
- independent activities of daily living/chore

- individual employment supports
- non-medical transportation
- nursing
- peer support
- personal care
- psychosocial rehabilitation
- respite
- short-term small group supported employment
- community transition services

Individuals enrolled in the Pathways program would be categorically ineligible for enrollment in the PROMISE program. Amendment, p. 3. For individuals enrolled in the DSHP and DSHP+ program, case management and services would be coordinated. Amendment, p. 3.

The Disabilities Law Program endorses the initiative subject to consideration of the following.

First, I highly recommend that Target Criteria A (pp. 3-5) be amended to include "Major Neurocognitive Disorder Due to TBI" (DSM-5), a/k/a Dementia Due to Head Trauma (294.1x) under DSM-IV. Consistent with Attachment "A", characteristics associated with Dementia Due to Head Trauma are described as follows:

These symptoms include aphasia, attentional problems, irritability, anxiety, depression or affective liability, apathy, increased aggression, or other changes in personality. Alcohol or other Substance Intoxication is often present in individuals with acute head injuries, and concurrent Substance Abuse or Dependence may be present.

Concomitantly, Target Criteria B should be amended to include at least trauma-based "Major Neurocognitive Disorders".

On a practical level, individuals with a diagnosis of "Major Neurocognitive Disorder Due to TBI" will generally present with an array of symptoms at least equivalent to the included PTSD, OCD, and anxiety-based disorders. The former individuals also frequently have co-occurring physical/spinal cord deficits which could be addressed with many of the supports in the services menu, including personal care, nursing, and respite. Moreover, the diagnosis of Major Neurocognitive Disorder Due to TBI requires persistent and significant impairments:

In DSM-5, not all brain injuries can be considered potentially causative of NCD (neurocognitive disorder). The diagnostic criteria for NCD due to TBI require that the TBI be associated with at least one of four features: loss of consciousness, posttraumatic amnesia, disorientation and confusion, or neurological signs, such as neuroimaging findings, seizures, visual field cuts, anosmia, or hemiparesis (Ref.5, p. 624). Furthermore, the NCD must have its onset either immediately after the TBI or after recovery of consciousness and must persist past the acute postinjury period. Thus, trauma that produced no cognitive or neurological changes at the time of the incident cannot produce an NCD under this scheme.

J. Simpson, M.D, Ph.D., DSM-5 and Neurocognitive Disorders, Journal of the American Academy of Psychiatry and the Law (June 1, 2014) (Attachment "B").

Second, there is some inconsistency/tension in the descriptions of choice of providers. Compare the following:

All adults receiving PROMISE services will have a choice of practitioner among the contracted and qualified providers. At 8

If the individual is identified as a CRISP individual, the individual will be enrolled in the PROMISE program only and will receive all services necessary for community living from the PROMISE program through CRISP. At 3.

The Department may wish to conform the reference on p. 8 to acknowledge the "CRISP" exception described on p. 3.

Thank you for the opportunity to share the above commentary.

Sincerely,



Brian J. Hartman
Project Director

cc: Kyle Hodges
Pat Maichle
Wendy Strauss

enc. (2)

EXCERPT

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

UNITED STATES OF AMERICA,)
)
 Plaintiff,)
)
 v.)
)
 STATE OF DELAWARE,)
)
 Defendant.)
)
)
)
)
)

CIVIL ACTION NO:

SETTLEMENT AGREEMENT

I. Introduction

- A. The State of Delaware (“the State”) and the United States (together, “the Parties”) are committed to full compliance with Title II of the Americans with Disabilities Act (“the ADA”), 42 U.S.C. § 12101 and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. This agreement is intended to ensure the State’s compliance with the ADA, the Rehabilitation Act, and implementing regulations at 28 C.F.R. Part 35, and 45 C.F.R. Part 84 (“Section 504”), which require, among other provisions, that, to the extent the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, throughout this document, the Parties intend that the principles of self-determination and choice are honored and that the goals of community integration, appropriate planning, and services to support individuals at risk of institutionalization are achieved.
- B. The United States Department of Justice (“United States”) initiated an investigation of Delaware Psychiatric Center (“DPC”), the State’s psychiatric hospital, in November 2007 and completed on-site inspections of the facility and community services in May 2008 and August 2010. Following the completion of its investigation, the United States issued a findings letter notifying the State of its conclusions on November 9, 2010.
- C. The State engaged with the United States in open dialogue about the allegations and worked with the United States to resolve the alleged violations of federal statutory rights arising out of the State’s operation of DPC and provision of community services for individuals with mental illness.

- D. In order to resolve all issues pending between the Parties without the expense, risks, delays, and uncertainties of litigation, the United States and the State agree to the terms of this Settlement Agreement as stated below. This agreement resolves the United States' investigation of DPC, as well as its ADA investigation.
- E. By entering into this Settlement Agreement, Delaware does not admit to the truth or validity of any claim made against it by the United States.
- F. The Parties acknowledge that the Court has jurisdiction over this case and authority to enter this Settlement Agreement and to enforce its terms as set forth herein.
- G. No person or entity is intended to be a third-party beneficiary of the provisions of this Settlement Agreement for purposes of any other civil, criminal, or administrative action, and accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Settlement Agreement in any separate action. This Settlement Agreement is not intended to impair or expand the right of any person or organization to seek relief against the State or their officials, employees, or agents.
- H. The Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331; 28 U.S.C. § 1345; and 42 U.S.C. §§ 12131-12132. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b).

II. Substantive Provisions

- A. In order to comply with this agreement, the State must prevent unnecessary institutionalization by offering the community-based services described in this Section (II) to individuals in the target population. The services must be developed and provided according to the implementation timeline described in Section III. The services may be provided directly by the State or through a contract managed by the State.

B. Target Population

- 1. The target population for the community services described in this section is the subset of the individuals who have serious and persistent mental illness (SPMI) who are at the highest risk of unnecessary institutionalization. SPMI is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria and has been manifest in the last year, has resulted in functional impairment which substantially interferes with or limits one or more major life activities, and has episodic, recurrent, or persistent features.

2. Priority for receipt of services will be given to the following individuals within the target population due to their high risk of unnecessary institutionalization:
 - a. People who are currently at Delaware Psychiatric Center, including those on forensic status for whom the relevant court approves community placement;
 - b. People who have been discharged from Delaware Psychiatric Center within the last two years and who meet any of the criteria below;
 - c. People who are, or have been, admitted to private institutions for mental disease ("IMDs") in the last two years;
 - d. People with SPMI who have had an emergency room visit in the last year, due to mental illness or substance abuse;
 - e. People with SPMI who have been arrested, incarcerated, or had other encounters with the criminal justice system in the last year due to conduct related to their serious mental illness; or
 - f. People with SPMI who have been homeless for one full year or have had four or more episodes of homelessness in the last three years;
3. People in the State who have SPMI may request services described in Section II of this agreement or may be referred for such services by a provider, family member, advocate, or State agency staff. Once the State receives a request or referral, the person with SPMI will be placed on the State's Target Population List.
4. Priority for receipt of services among those on the Target Population List will go to people who meet one of the criteria listed in II.B.2.a-f.

C. Crisis Services

1. The State shall develop a statewide crisis system. The crisis system shall:
 - a. Provide timely and accessible support to individuals with mental illness experiencing a behavioral health crisis, including a crisis due to substance abuse;
 - b. Stabilize individuals as quickly as possible and assist them in returning to their pre-crisis level of functioning;

through this demonstration to waiver 1902(a)(23). Such authority will allow non-medical transportation services be delivered through HCBS authorities.

PROMISE Reporting, Program Monitoring, and Quality Management

In order to ensure strong management of the SPMI and SUD populations, data will be monitored and aggregated consistent with the State's definitions under the PROMISE program.

The State will develop HCBS performance measures and monitoring consistent with the State's managed long term supports and services program (i.e., DSHP Plus) and already existing standard terms and conditions for the population under the existing demonstration including the quality of life measurements outlined in the Olmstead settlement. The State will comply with all federal HCBS requirements upon initial implementation of the PROMISE program.

Adults Not Meeting PROMISE Eligibility Criteria

All adult BH services for individuals over 18 not meeting PROMISE targeting and functional criteria will be delivered through the MCO benefit package effective with the MCO reprocurement. Adults not eligible for the PROMISE program will receive the following State Plan services through their MCOs:

- Hospital (inpatient general hospitals and psychiatric units; ER; outpatient; inpatient psychiatric for those under age 21).
- Physician — all types.
- Pharmacy — excluding medicated assisted therapy (MAT).
- Crisis intervention.
- SUD services, including MAT.
- Services by licensed BH practitioners.

Until MCO re-procurement, the MCO benefit package for BH will remain unchanged for all Medicaid members.

In short, beneficiaries who do not meet the PROMISE criteria are enrolled in managed care and all behavioral benefits for which they are eligible are provided under that delivery system. The goal of incorporating the BH services for the general adult population in the MCOs is to improve access to appropriate physical and BH care services for individuals with mild to moderate mental illness or SUDs; to better manage total medical costs for individuals with co-occurring BH/PH conditions; and to improve health outcomes and beneficiary satisfaction. This portion of the amendment will eliminate the artificial service limits previously in place, align better with the intent of mental health parity, and eliminate restrictions on MCOs' ability to manage enrollees health care including BH.

Implementation of the Demonstration

BH services using the delivery systems above will be implemented with the following phase-in schedules:

- Delaware DSAMH will issue requests for proposals (RFPs) and openly procure FFS contracts for providers of PROMISE benefits and care management as needed for adults meeting targeting and functional needs criteria to provide HCBS services under the PROMISE program for implementation no later than January 1, 2015.



signed 7-21-14

SPONSOR: Sen. Hall-Long & Rep. Barbieri
Sens. Blevins, Bushweller, Hocker, Sokola, Townsend; Reps.
Briggs King, Gray, Heffernan, Q. Johnson, Mitchell,
Mulrooney, Paradee, B. Short, D.E. Williams, Wilson

DELAWARE STATE SENATE

147th GENERAL ASSEMBLY

SENATE BILL NO. 246
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO EMERGENCY MEDICATION IN SCHOOLS.

WHEREAS, the American Academy of Pediatrics has estimated that one in 25 school aged children are affected by food allergies, and has stated that food allergies are the most common trigger of anaphylaxis among school aged children; and

WHEREAS, anaphylaxis is a severe, potentially fatal, systemic allergic reaction that occurs suddenly after contact with an allergy-causing substance; and

WHEREAS, studies have indicated that 16% to 18% of children with food allergies have experienced a reaction in school; and

WHEREAS, approximately 25% of all anaphylaxis cases triggered by food allergies occur in children whose food allergy was previously undiagnosed; and

WHEREAS, the Centers for Disease Control and Prevention have stated that delays in using epinephrine have resulted in near fatal and fatal allergy reactions in schools; and

WHEREAS, the Centers for Disease Control and Prevention have therefore recommended that schools consider keeping multiple doses of epinephrine onsite so they can respond quickly to a food allergy emergency; and

WHEREAS, the federal School Access to Emergency Epinephrine Act was signed into law in 2013, and provides preference in receiving certain federal public health grants to states whose public schools maintain supplies of epinephrine and ensure that trained personnel are present and can administer epinephrine to students reasonably believed to be having anaphylactic reactions and can receive appropriate legal protection for doing so; and

WHEREAS, the State of Delaware's Division of Public Health has already issued Medical Emergency Standing Orders for Allergic Reactions and Anaphylaxis for Use by Public/Charter School Registered Nurses that include a requirement that epinephrine be located on-site at each school.

NOW THEREFORE:

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 30, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

CHAPTER 30E. SCHOOL ACCESS TO EMERGENCY MEDICATION ACT

§ 3001E Definitions.

As used in this chapter:

(1) "Emergency Medication" means a medication necessary for response to a life-threatening allergic reaction.

(2) "Licensed Healthcare Provider" means anyone lawfully authorized to prescribe medications and treatments.

(3) "School" means an educational facility serving students in kindergarten through grade 12, and any associated pre-kindergarten program in such facility.

(4) "School Nurse" means a Registered Nurse employed by a local education agency meeting the certification and licensure requirements of the employing agency.

(5) "Trained Person" means an educator, coach or person hired or contracted by schools serving students in pre-kindergarten through grade 12 who has completed the training to administer Emergency Medicine to diagnosed and undiagnosed individuals.

(6) "Without an Order" means that the School Nurse or Trained Person may administer Emergency Medication, as further described within this Chapter, without an individual prescription from a Licensed Healthcare Provider for a person to receive the Emergency Medication. In lieu of a Licensed Healthcare Provider's order, i.e., an individual prescription, the Division of Public Health will issue guidance for administration Emergency Medication in the School setting. The Division of Public Health will continue to provide Medical Emergency Standing Orders for Allergic Reactions and Anaphylaxis in Previously Undiagnosed Individuals for Use by Public / Charter School Registered Nurses.

§ 3002E. Responsibilities of the Department of Education.

(a) The Department of Education shall adopt rules and regulations regarding Emergency Medication, including but not limited to the training of Trained Persons and documentation thereof, and the storage, provision and administration of Emergency Medication and documentation thereof.

§ 3003E. Responsibilities of the Division of Public Health.

(a) The Division of Public Health shall provide guidance on the administration of Emergency Medications without an Order in the school setting to undiagnosed individuals. The Division of Public Health will continue to provide Medical Emergency Standing Orders for Allergic Reactions and Anaphylaxis in Previously Undiagnosed Individuals for Use by Public / Charter School Registered Nurses.

§ 3004E. Responsibilities of the School.

(a) The School Nurse, in consultation with the school administration, shall identify and train a sufficient number of eligible persons willing or required by position to become Trained Persons to administer Emergency Medication.

(b) The School shall maintain stock Emergency Medication.

§ 3005E. Training.

(a) The Department of Education shall develop, for approval by the Division of Public Health, a training course to prepare Trained Persons to administer Emergency Medications to diagnosed and undiagnosed individuals.

(b) Except for a school nurse, an educator, coach or person hired or contracted by schools serving students in pre-kindergarten through grade 12 shall not be compelled to become a Trained Person, unless this is a requirement of hire or contract.

§ 3006E. Storage of Emergency Medication.

(a) Emergency Medication which shall be administered by the School Nurse, shall be located in a secure but accessible area which is easily accessible to the School Nurse.

(b) Emergency Medication which shall be administered by a Trained Person, shall be located in a secure but accessible area, which is identified by the School as easily accessible.

§ 3007E Provision of limited liability protections.

(a) Any Trained Person or School Nurse, who, in good faith and without expectation of compensation from the person aided or treated, renders emergency care or treatment in response to an apparent allergic reaction by the use of an Emergency Medication shall not be liable for damages for injuries alleged to have been sustained by the aided or treated person or for damages for the death of the aided or treated person alleged to have occurred by reason of an act or omission in the rendering of such emergency care or treatment, unless it is established that such injuries or such death were caused wilfully, wantonly or by gross negligence on the part of the trained person or school nurse who rendered the emergency care or treatment by the use of an Emergency Medication.



Tyler Edwards, 12, gives advice to his mother, Tammy Edwards (left) who is cutting Catherine Gaston's hair at Edwards' salon in Hendersonville, Tenn. Tyler has several food allergies, and Tammy lobbied for legislation that would allow schools to stock injection devices to treat allergic reactions. AP

More states allow schools to stock epinephrine drug

By Lucas L. Johnson II
Associated Press

NASHVILLE, Tenn. — When a third-grade student who had been stung by a wasp developed welts on his neck and had trouble breathing, school nurse Amanda Williams had the necessary dose of epinephrine to counter the allergic reaction.

A law Tennessee enacted this year makes it easier for schools to stock the life-saving drug. Williams said the emergency room doctor told the boy's parents that he probably wouldn't have survived without the injection at Tellico Plains Elementary because it's a 30-minute drive to the hospital.

"It would have been tragic," she said.

Fifteen other states enacted similar laws in 2013, joining 11 others that already had them, according to the Asthma and Allergy Foundation of America. Only four of the states require schools to have the medication on hand. But all the laws allow schools to stock it

without a prescription for an individual person — a legal hurdle in many places — and provide legal protection for staff members who administer it.

The most common form of the medication is packaged inside a device called an autoinjector. The tip of the device is placed firmly against the thigh, which releases a short, spring activated needle that injects the epinephrine.

Charlotte Collins, senior vice president of public policy and advocacy for the allergy foundation, has been tracking which states are enacting laws to encourage schools to stock the devices. She believes the trend was sparked by last year's death of a Virginia first-grader who had an allergic reaction on a playground after eating a nut. She went into cardiac arrest and died at a hospital.

Medical experts have said the little girl, who had a peanut allergy, would probably be alive if her elementary school had been able to give her an epinephrine injection.

Jeanne A. Carpenter
Epilepsy Legal Defense Fund

**Diastat Administration in Schools
Summary of Relevant Federal Laws and Selected Cases**

Background on Medication in School and Day Care

Schools and day care facilities all too often refuse to permit their staff to administer a FDA-approved emergency medication, Diastat, to treat children who have prolonged seizures accompanied by loss of consciousness. Instead, schools and day care facilities will frequently call 911 to transport the child to an emergency room for treatment, even if this practice is contrary to the care plan established by the child's neurologist. Delay in administering Diastat for the time it takes emergency personnel to arrive could result in neurological damage or other serious health consequences.

In public schools, administrators frequently assert this practice is justified because their schools lack personnel with necessary expertise, or they may assert that state laws permit only RNs (who may not be immediately available at the school) to administer this medication. And in the case of day care programs, it is argued that such health services are beyond their capacity or design, and therefore are not required. However, these arguments are unjustified because Diastat may be appropriately administered by non-medical personnel.

Courts and hearing officers have ruled that schools and day care facilities are indeed required to ensure that Diastat, and similar medications such as for treatment of diabetes, are administered to comply with the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act and ADA. These laws require school and day care administrators to ensure that health services and accommodations are provided for children with epilepsy and other disabilities. The Foundation's position statement on these matters is available at

<http://www.epilepsyfoundation.org/advocacy/care/treatments.cfm>. For general information on the legal issues, see the EpilepsyUSA article on the subject from 2003, available at <https://www.epilepsyfoundation.org/epilepsyusa/schooldiastat.cfm>.

In order to address concerns raised by school and day care administrators, Epilepsy Foundation affiliates have pursued a range of different advocacy strategies, including efforts to change the state laws that may restrict school personnel from administering this medication. For instance, last year, largely as the result of the efforts by the Kentuckiana Affiliate, the Kentucky Governor signed into law a bill that provides for the administration of Disastat (along with glucagon for diabetes treatment) in public, private and parochial schools. The statute provides that schools shall require that at least one



school employee, who has met state competency requirements (and consents to provide the medication) be on duty at each school during the entire day to administer Disastat (and glucagon) in an emergency. The law is available on the Kentucky Legislature's Web site at <http://www.lrc.ky.gov/record/05rs/HB88.htm> (click on the last link – "FCCR").

Other affiliates have been successful in promoting similar amendments to state laws, regulations and practices in this area. See the accompanying chart for information on other state laws pertaining to medication administration in school.

Federal Laws Applicable to Public Schools

The following is a brief outline of the primary federal laws that establish rights and remedies concerning services for public school students with disabilities, including epilepsy.¹ For more information, please see the Foundation fact sheet on the subject, which was prepared for consumers and advocates, available at <http://epilepsyfoundation.org/answerplace/Legal/educationlaw/Education.cfm>. See also the education resources for consumers on the Defense Fund's Web site at <http://epilepsyfoundation.org/epilepsylegal/consumerresources.cfm>.

Section 504

Section 504 of the Rehabilitation Act prohibits schools that receive federal funding from discriminating against a child because of disability in academic and nonacademic activities, such as school field trips and extracurricular activities. The law also requires schools to provide a reasonable accommodation to a child who is otherwise qualified to participate in the particular activity. A reasonable accommodation is a modification in a program or policy, or an auxiliary aid that enables an individual with a disability to participate in a program.²

¹ The remainder of this discussion addresses legal protections that apply in the public school context and does not address day care providers. Also, a discussion of the obligations of private schools, including parochial schools, is beyond the scope of this outline. Note, however, that parochial schools in particular present special concerns, as such schools are covered under federal law (Section 504 of the Rehabilitation Act) only to the extent they receive (directly or indirectly) federal financial assistance. We would be glad to provide more information on the legal issues relating to day care providers and private schools upon request.

² Title II of the ADA applies to public schools as well. Because Section 504 contains more specific implementing regulations than the ADA with respect to the operation of schools, the Department of Education's Office for Civil Rights (OCR), which enforces both Section 504 and Title II of the ADA, generally relies on Section 504 and its implementing regulations.



Under Section 504, schools may not deny students with disabilities the opportunity to participate in or benefit from any aid, benefit or service afforded to their peers without disabilities, even if a modification or accommodation must be provided to allow participation. Section 504 requires public schools receiving federal funds to provide a free and appropriate education to all qualified students with disabilities in their jurisdiction.³ An "appropriate" education is one that provides regular or special education services and related aids designed to meet the educational needs of students with disabilities.

Section 504 may be enforced by filing a complaint with OCR. Alternatively, individuals have the option of filing litigation in federal court to enforce their rights.

IDEA

The Individuals with Disabilities Education Act (IDEA) is a federal program under which states receive federal funds for special education services in exchange for their provision of certain special education requirements. The primary requirement is that students with disabilities receive a free appropriate public education that conforms to their individualized education program (IEP).

Unlike the ADA and Section 504, which are both anti-discrimination statutes designed to "level the playing field," IDEA imposes affirmative obligations on states and school districts to provide services to specific classes of students. To qualify for protection under IDEA, a child must have a disability that adversely affects his or her ability to learn, and thus needs "special education" and "related services."

"Special education" includes instruction that is specifically designed to meet the child's unique needs that result from a disability. It can involve adapting the content, methodology or delivery of the instruction. "Related services" include "transportation and such developmental, corrective and other supportive services (including . . . medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability benefit from special education." The IDEA regulations also include "school health services" as a related service and define "school health services" as services provided by a qualified school nurse or other qualified person.

³ At times, a school may assert that a student with a seizure disorder is not entitled to coverage under Section 504 because he or she is not "substantially limited" in a major life activity. This claim may be based on the fact that the disorder is controlled by medication. (In 1999, the Supreme Court issued a series of decisions ruling that, in determining whether a condition is substantially limiting, the effects, both negative and positive, of "mitigating measures" -- such as medication -- must be considered.) However, OCR has issued guidance clarifying that this analysis does not apply in the school context -- when permission on the part of the school is required for a student to access medication or other treatment.



As discussed in the case summaries below, the administration of Diastat may be considered to be a required "related service" under IDEA. It also may be viewed as a required reasonable accommodation under Section 504.

Disabilities covered under IDEA may include health impairments such as epilepsy, as well as traumatic brain injuries, learning disabilities, mental retardation and autism. (A child with epilepsy or another disability who does not qualify for services under IDEA may, however, qualify for services under Section 504 of the Rehabilitation Act, as discussed above.)

In enforcing rights under IDEA, an individual must exhaust state level administrative procedures. This process generally involves requesting mediation, a due process hearing (involving an impartial hearing officer who renders an opinion), or filing a complaint with the State education agency. A party dissatisfied with the final state determination may have it reviewed by filing litigation in federal court.

Selected Cases involving School Administration of Diastat

IDEA Cases

Silsbee Independent School Dist., 25 IDELR 1023 (Tex. SEA 1997).

The hearing officer held that calling 911 was not an appropriate response where treatment for a seizure disorder was needed, because there was no guarantee an ambulance would arrive within any particular time frame, despite the fact that a hospital was nearby. The student in this case was a seven-year old first grader who experienced convulsive seizures, along with drop apnea. The school had a seizure protocol, which involved having school personnel turning the student, Steve, on his side, timing the seizure, contacting the school nurse and administering Diastat if his seizure and apnea lasted for three minutes or more.

Steve's neurologists recommended to the school district that Diastat be administered only by a RN and not a LVN, and that the RN be on-call and available at all times. The neurologists had indicated that this procedure requires a RN due to potential complications, including the possibility of puncture with the needle and the perforating of the bowel when inserting the hard syringe during convulsions. (At the time this case was heard, administration of the medication involved drawing it from a glass ampule by a needle and syringe and removing the needle before inserting the syringe.) The school district requested the due process hearing to determine whether providing a RN, as opposed to a LVN, is required by IDEA as a related service and whether training of teachers and staff in seizure response is such a required service.

The hearing officer ruled that the school must ensure that a RN or other equally qualified person capable of administering the medication rectally in case of prolonged seizure is in close proximity to the student at all times during the school day. The presence of such a person on the school campus, the hearing officer concluded, is a



supportive service necessary to assist Steve in receiving a benefit from his special education. The hearing officer also clarified that maintaining a full-time RN on campus does not amount to a "medical service," which the school district is not required to provide, as clarified under relevant Supreme Court decisions.⁴

The hearing officer also determined that having staff resuscitate Steve using oxygen (an AMBU bag) is a required related supportive service.

Student v. San Francisco Unified School District, No. 2331 (CA Special Education Hearing Office 2002)

In this case, a positive decision along the lines of that in *Silsbee* above was reached. However, unlike *Silsbee*, in this case, the school district had refused altogether to administer Diastat and would call 911 as its only response to a prolonged seizure of five minutes or more.

The school district had asserted that the possibility of respiratory complications and the need to provide respiratory intervention places the administration of Diastat outside the scope of mandatory special education services. The hearing officer found that the evidence indicated that there is no unreasonable risk of respiratory complications for this student, and that in any event, such possible complications can be effectively addressed by a trained professional aide.

The hearing officer ruled that the implementation of the protocol of the student's neurologist for the administration of Diastat by qualified District personnel is necessary to make public education meaningfully accessible to the student. It was also found that the protocol is necessary to meet the student's unique needs and afford him an educational benefit. The protocol, therefore, is a related service the District must provide. The State Hearing Officer opinion is available on-line at http://www3.scoe.net/speced/seho/seho_search/sehoSearchDetails.cfm?ID=1742.

Christian v. Clark County School District (Nevada State Review Officer Opinion, 2004). In this case, a state review officer, affirming the due process hearing officer's decision, found that the school in issue was not required to provide a full-time nurse at the child's neighborhood school to administer Diastat.

A nine-year old student with a seizure disorder enrolled in a local school after spending his first two years of elementary school being home-schooled. His mother requested that either she or a school nurse be on school grounds at all times in case the child

⁴ There are two interpretations of this issue. One interpretation holds that if the service only can be provided by a physician, it is a medical service that the school need not provide. Another interpretation holds that if the service is too burdensome for the school, it need not provide it. The hearing officer found that, under either interpretation, maintaining a RN full-time is a required school health service.



needed Diastat; however, the school district stated that its emergency seizure management protocol (calling 911) was sufficient and that it was not required to provide the services of qualified personnel for this purpose. The district offered the option of reassigning the student to a school six miles away, where a registered nurse is present at all times.

The State Review Officer (SRO) found no indication on the student's IEP that the school district was required to allow the mother to stay at the school to administer the Diastat. Under IDEA, a school district has the discretion in choosing a provider of services; therefore, it need not grant a parent's request to be designated as such. In addition, the policy of the Nevada State Board of Nursing requires that Diastat be given by a nurse, distinguishing this case from the *San Francisco Unif. School District* case, where California law permitted administration of Diastat by either a school nurse or other qualified personnel.

The SRO went on to state that even if the student's medical needs required the presence of a nurse on school grounds at all times, the student does not have an automatic right to be educated at the neighborhood school. The court relied on *White v. Accession Parrish Sch. Bd.*, 39 IDELR Para. 182 (5th Cir. 2003) (upholding a school district's decision to provide centralized services for students with hearing impairments where only one student would utilize the service).

The mother countered that requiring her son to attend a different school would be inconvenient and potentially frightening because he would be away from his siblings; however, the SRO stated that these arguments were "in part just not true and on balance are trivial compared to meeting all of the Petitioner's education needs!"

Nursing Practice Act Cases

Lancaster School District Support Association v. Board of Education, Lancaster City School District, No. 03 CVH 02 02143 (Ohio Ct. of Common Pleas March 6, 2006), *appeal pending*. In this case, a school union filed an action objecting to two of its members, educational assistants, being designated by the school board to administer Diastat to a student with epilepsy. This service was a part of the child's IEP and the union asserted that the directive to these employees to administer the medication violates the State Nurse Practice Act ("the Act"), arguing that it would amount to an unauthorized practice of nursing, in violation of the Act. The court ruled (the sole issue it addressed) that these employees' administration of Diastat would not violate the Act and is permissible.

The Act requires licensed nurses alone to administer medication (and to provide other treatment) when doing so requires specialized knowledge, judgment and skill derived from the nursing sciences. The court noted that the Act contains an exception in emergency situations. Another state law allows the school board to authorize non-



medically trained employees to administer prescribed drugs if certain conditions are met, such as a signed parental request, instructions from the prescribing physician and appropriate training for employees. The court found that the two laws together authorize a school board to establish a policy whereby an unlicensed employee can administer prescribed medication that does not require the exercise of independent nursing judgment contemplated by the Act.

The court determined that administering Diastat does not require such independent judgment, and therefore, is not a violation of the Act. Also, the court noted that administering Diastat to a child experiencing a generalized seizure constitutes a medical emergency, and therefore falls under an exception to the Act. (Here the court rejected the rather weak argument of the union that because the child is known to experience seizures, it is not an "emergency" when they do occur.)

In reaching its conclusion about the level of judgment needed to administer the medication, the court was persuaded by the testimony of an expert witness, Dr. Glauser. This witness testified that the medication can be safely administered by an individual with a grade school level of education. Dr. Glauser noted that Diastat is not associated with respiratory depression, as is intravenous administration of valium, and thus, does not require medical expertise to monitor side effects. The court found that the student's IEP calls for emergency medical personnel to be called after medication administration, thus minimizing the responsibility of school employees to monitor the child post-administration.

The court concluded by observing that "Unfortunately, it does not appear possible for a school nurse to be present at all times in very school building. Accordingly, just as it is important for education professionals to be trained in other life preserving emergency procedures such as the Heimlich maneuver or CPR, it is important that educational professionals become adequately trained at administering this potentially life saving medication."

Cases Involving Diabetes Care in Schools

In the diabetes context, schools may be required to assist children in administering glucagon because failure to do so may effectively deny needed services to students with disabilities, in violation of Section 504. Glucagon is given when a child has lost consciousness due to severe hypoglycemia, and must be injected; failure to administer the medication in a timely fashion can be life threatening. The American Diabetes Association believes that a school's decision to call "911" rather than administer a Glucagon injection unnecessarily denies treatment, and that the appropriate response is to both give the injection and call emergency services.

Although many schools take the position that glucagon may only be administered by a nurse or other health care professional, the inability to delegate these tasks does not



diminish the schools' responsibility to provide the service. In several disputes heard by the Department of Education's Office for Civil Rights, it was determined that the lack of a school nurse does not release a school from its obligation to provide required medical services for students with diabetes. See, for instance, *Prince George's (MD) County Schools*, Complaint No. 03-02-1258, 39 IDELR 103 (OCR 2003); *Hasbrouck Heights Sch. Dist.*, Complaint No. 02-01-1121 (OCR 2001).

W:\WPGROUPS\LEGADV\LegalDefenseFund\Affiliate Coordination\Diastat\LegalOutline.doc





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: June 25, 2014

TO: Ms. Elizabeth Timm, DFS
Office of Child Care Licensing

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 17 DE Reg. 1155 [DFS Proposed Early Care & Education & School-Age Center Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Services for Children, Youth and Their Families/Division of Family Services (DFS)/Office of Child Care Licensing's proposal to adopt a wholesale revision of its *DELACARE Rules for Early Care and Education and School-Age Centers* regulation. The proposed regulation was published as 17 DE Reg. 1155 in the June 1, 2014 issue of the Register of Regulations. Given the length of the regulations and time constraints, SCPD only "skimmed" the proposed standards, but has the following observations.

First, SCPD was unable to identify any general non-discrimination provision, including a provision barring discrimination based on disability. SCPD noted only isolated and oblique references (e.g. §25.1.3). Compare 14 DE Admin Code 225 for DOE equivalent. In the 1990s the Division's regulations routinely contained such provisions. See, e.g., attached excerpts from former regulations. In its December 19, 2007 commentary on proposed DFS regulations covering child care homes, the SCPD offered the following recommendation:

2. Although there are a few cryptic references to "nondiscrimination" (e.g. §29.1.2), the regulations do not mention or proscribe discrimination based on race, disability, or other protected classes. At a minimum, §7.2.3 could be renumbered §7.2.4 and the following new §7.2.3 inserted:

7.2.3 Commitment to comply with applicable non-discrimination laws, including the Americans with Disabilities Act [42 U.S.C. 12101] and Delaware Equal Accommodations Law [Title 6 Del.C. Ch. 45].

Attached please find a December 2, 1991 Delaware Attorney General's Opinion holding that day care centers are covered by both the ADA and Delaware Equal Accommodations law.

Indeed, consistent with the attached Attorney General's Opinion, DFS offered training on daycare center compliance with the ADA in the past. See attached May 9, 1996 excerpt from "DayCare Centers and the Americans with Disabilities Act".

The bottom line is that the current regulation would benefit from an affirmative requirement that providers comply with the ADA and Equal Accommodations law in their programs. Concomitantly, there are a number of provisions in the proposed regulation which may be "at odds" with the Attorney General's opinion and the ADA. See, e.g., §§59.1 (children excluded if unspecified illness limits child's comfortable participation or extra care needs compromise health and safety of other children); 17.4.1 (implication that programs may discourage enrollment based on special needs).

Second, §13.0 lists several "events" requiring reporting to DFS. There is no mention of reporting extended physical restraint which is ostensibly not limited by §§64.4 and 65.4. Compare Title 16 Del.C. §5162(a)(2) and 17 DE Reg. 1133, 1137, §6.1.2 (June 1, 2014). SCPD recommends that DFS require the reporting of physical restraint above a certain threshold (e.g. 10 minutes).

Third, §41.0 requires children to wear helmets if riding a bike with wheels of 20 or more inches. The State law requiring children to wear helmets [Title 21 Del.C. §4198K] does not exempt children riding on bikes with smaller wheels. The "20 inch" standard for bikes should be deleted.

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

cc: Ms. Vicky Kelly
Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

17reg1155 dscyf-dfs early care education and school-age center 6-23-14